

HEALTH POLICY 101

Congress, the Executive Branch, and Health Policy

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

[Medicare 101](#)

[Medicaid 101](#)

[The Affordable Care Act 101](#)

[Employer-Sponsored Health Insurance 101](#)

[The Uninsured Population and Health Coverage](#)

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[International Comparison of Health Systems](#)

[The U.S. Government and Global Health](#)

[The Role of Public Opinion Polls in Health Policy](#)

[Congress, the Executive Branch, and Health Policy](#)

[The Politics of Health Care and the 2024 Election](#)

Introduction

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

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

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

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

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

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

Dr. Drew Altman
CEO, KFF

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Introduction

The federal government is not the only place health policy is made in the U.S., but it is by far the most influential. Of [the \\$4.5 trillion the U.S. spent on health in 2022](#), the federal government was responsible for roughly a third of all health services. The payment and coverage policies set for the Medicare program, in particular, often serve as a model for the private sector. Many health programs at the state and local levels are also impacted by federal health policy, either through direct spending or rules and requirements. Federal health policy is primarily guided by Congress, but carried out by the executive branch, predominantly by the Department of Health and Human Services.

The Federal Role in Health Policy

No one is “in charge” of the fragmented U.S. health system, but the federal government probably has the most influence, a role that has grown over the last 75 years. Today the federal government pays for care, provides it, regulates it, and sponsors biomedical research and medical training.

The federal government pays for health coverage for well over 100 million Americans through Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), the Veterans’ Health Administration, the Indian Health Service, and the Affordable Care Act (ACA). It also pays to help provide insurance coverage for tens of millions who are active-duty and retired military and for civilian federal workers.

Federal taxpayers also underwrite billions of dollars in health research, mainly through the [National Institutes of Health](#) (NIH) and the [Agency for Healthcare Research and Quality](#) (AHRQ).

Federal public health policy is spearheaded by the [Centers for Disease Control and Prevention](#). Its portfolio includes tracking not just infectious disease outbreaks in the U.S. and worldwide, but also conducting and sponsoring public health research and tracking national health statistics.

[The Health Resources and Services Administration](#) (HRSA) funds critical health programs for underserved Americans (including Community Health Centers) and runs workforce education programs to bring more health services to places without enough health care providers.

Meanwhile, in addition to overseeing the nation’s largest health programs, the [Centers for Medicare and Medicaid Services](#) (CMS) also operates the federal insurance Marketplaces created by the ACA and enforces rules made by the law for private insurance policies.

While the federal government exercises significant authority over medical care and its practice and distribution, state and local governments still have key roles to play.

States oversee the licensing of health care professionals, distribution of health care resources, and regulation of health insurance plans that are not underwritten by employers themselves. State and local governments share responsibility for most public health activities and often operate safety-net facilities in areas with shortages of medical resources.

The Three Branches of Government and How They Impact Health Policy

All three branches of the federal government – Congress, the executive branch, and the judiciary – play important roles in health policy.

Congress makes laws that create new programs or modify existing ones. It also conducts “oversight” of how the executive branch implements the laws Congress has passed. Congress also sets the budget for “discretionary” and “mandatory” health programs (see below) and provides those dollar amounts.

The executive branch carries out the laws made by Congress and operates the federal health programs, often filling in details Congress has left out through rules and regulations. Federal workers in the health arena may provide direct patient care, regulate how others provide care, set payment rates and policies, conduct medical or health systems research, regulate products sold by the private sector, and manage the billions of dollars the federal government spends on the health-industrial complex.

Historically, the judiciary has had the smallest role in health policy but has played a pivotal role in recent cases. It passes judgment on how or whether certain laws or policies can be carried out and settles disputes between the federal government, individuals, states, and private companies over how health care is regulated and delivered. Recent significant decisions from the Supreme Court have affected the legality and availability of abortion and other reproductive health services and the constitutionality of major portions of the ACA.

The Executive Branch – The White House

Although most of the executive branch’s health policies are implemented by the Department of Health and Human Services (and to a smaller extent, the Departments of Labor and Justice), over the past several decades the White House itself has taken on a more prominent role in policy formation. The White House Office of Management and Budget not only coordinates the annual funding requests for the entire executive branch, but it also reviews and approves proposed regulations, Congressional testimony, and policy recommendations from the various departments. The White House also has its own policy support agencies – including the National Security Council, the National Economic Council, the Domestic Policy Council, and the Council of Economic Advisors, that augment what the President receives from other portions of the executive branch.

How the Department of Health and Human Services is Structured

Most federal health policy is made through the [Department of Health and Human Services](#). Exceptions include the [Veterans Health Administration](#), run by the Department of Veterans Affairs; [TRICARE](#), the health insurance program for active-duty military members and dependents, run by the Defense Department; and the [Federal Employees Health Benefits Program](#) (FEHB), which provides health insurance for civilian federal workers and families and is run by the independent agency the Office of Personnel Management.

The health-related agencies within HHS are roughly divided into the resource delivery, research, regulatory, and training agencies that comprise the U.S. Public Health Service and the health insurance programs run by the Centers for Medicare and Medicaid Services (CMS).

Ten of the [13 operating divisions of HHS](#) are part of the U.S. Public Health Service, which also plays a role in U.S. global health programs. They are:

- The Administration for Strategic Preparedness and Response (ASPR)
- The Advanced Research Projects Agency for Health (ARPA-H)
 - The Agency for Healthcare Research and Quality (AHRQ)
 - The Agency for Toxic Substances and Disease Registry (ATSDR)
 - The Centers for Disease Control and Prevention (CDC)
 - The Food and Drug Administration (FDA)
 - The Health Resources and Services Administration (HRSA)
 - The Indian Health Service (IHS)
 - The National Institutes of Health (NIH)
 - The Substance Abuse and Mental Health Services Administration (SAMHSA)

The [Centers for Medicare and Medicaid Services](#) (CMS) is by far the largest operating division of HHS. It oversees not just the Medicare and Medicaid programs, but also the federal Children's Health Insurance Program (CHIP) and the health insurance portions of the Affordable Care Act. Together, the programs under the auspices of CMS account for [nearly a quarter of all federal spending in fiscal 2023](#), cost an estimated \$1.5 Trillion in fiscal 2023, and [served more than 170 million Americans](#) – more than half the population.

Who Makes Health Policy in Congress?

How Congress oversees the federal health care-industrial complex is almost as byzantine as the U.S. health system itself. Jurisdiction and responsibility for various health agencies and policies is divided among more than two dozen committees in the House and Senate (Tables 1 and 2).

In each chamber, however, three major committees deal with most health issues.

In the House, the [Ways and Means Committee](#), which sets tax policy, oversees Part A of Medicare (because it is funded by the Social Security payroll tax) and shares jurisdiction over other parts of the Medicare program with the Energy and Commerce Committee. Ways and Means also oversees tax subsidies and credits for the Affordable Care Act and tax policy for most employer-provided insurance.

The [Energy and Commerce Committee](#) has sole jurisdiction over the Medicaid program in the House and shares jurisdiction over Medicare Parts B, C, and D with Ways and Means. Energy and Commerce also oversees the U.S. Public Health Service, whose agencies include the Food and Drug Administration, the National Institutes of Health, and the Centers for Disease Control and Prevention.

While Ways and Means and Energy and Commerce are in charge of the policymaking for most of the federal government's health programs, the actual amounts allocated for many of those programs are determined by the [House Appropriations Committee](#) through the annual Labor-Health and Human Services-Education and Related Agencies spending bill.

In the Senate, responsibility for health programs is divided somewhat differently. The [Senate Finance Committee](#), which, like House Ways and Means, is in charge of tax policy, oversees all of Medicare and Medicaid and most of the ACA.

The Senate counterpart to the House Energy and Commerce Committee is the [Senate Health, Education, Labor and Pensions Committee](#), which has jurisdiction over the Public Health Service (but not Medicare or Medicaid).

The [Senate Appropriations Committee](#), like the one in the House, sets actual spending for discretionary programs as part of its annual Labor-HHS-Education spending bill.

Table 1

Senate Committees with Health Jurisdiction

Of the Senate's 20 standing committees, 12 have significant health jurisdiction. They include:

Committees	Health Jurisdiction
Appropriations	Allocates discretionary spending, mostly via the Labor-HHS-Education and Related Agencies spending bill.
Armed Services	Makes policy for health care for active-duty military and dependents, as well as retired military.
Budget	Receives the President's budget request, writes the annual budget resolution, and oversees the budget reconciliation process.
Commerce, Science and Transportation	Handles issues related to consumer protection, health IT and other technology issues, and tobacco policy.
Finance	Oversees Medicare, Medicaid, the insurance portions of the Affordable Care Act, the Children's Health Insurance Program, as well as tax policies related to employer-provided health insurance, health savings accounts, and flexible spending accounts.
Foreign Relations	Handles global health issues, including AIDS, Ebola and other infectious diseases, as well as international family planning and reproductive health issues.
Health, Education, Labor and Pensions	Oversees programs of the U.S. Public Health Service Act; aging issues, and labor issues including the Employee Retirement Income Security Act (ERISA).
Indian Affairs	Native American health, including the Indian Health Service (IHS).
Judiciary	Medical malpractice, anti-trust, and health care provided in federal prisons.
Small Business	Small business health insurance issues.
Veterans Affairs	Oversees the Veterans' Health Administration, which provides care to an estimated nine million enrolled veterans.
Select Committee on Aging	Does not direct legislative jurisdiction, but conducts oversight and investigations of issues related to aging and older Americans.

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Table 2

House Committees with Health Jurisdiction

In the House, 13 of 21 standing committees have jurisdiction over some health issues. They include:

Committees	Health Jurisdiction
Agriculture	Same as Senate
Appropriations	Same as Senate
Armed Services	Same as Senate
Budget	Same as Senate
Education and the Workforce	This House committee has the same labor and pension jurisdiction as the Senate Health, Education, Labor and Pensions Committee.
Energy and Commerce	Oversees the U.S. Public Health Service agencies, plus the Medicaid program. Shares jurisdiction with Ways and Means over Medicare parts B, C, and D.
Foreign Affairs	Same as Senate
Judiciary	Same as Senate
Natural Resources	Native American Health
Oversight and Accountability	The primary investigative committee in the House is a watchdog for all federal agencies, including HHS. It also has direct jurisdiction over the Federal Employee Health Benefits Plan.
Small Business	Same as Senate
Ways and Means	Exclusive jurisdiction in the House over Medicare Part A and health-related tax policy, plus shared jurisdiction over Medicare Part B, C, and D with Energy and Commerce.
Veterans Affairs	Same as Senate

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The Federal Budget Process

Under Article 1 of the [U.S. Constitution](#), Congress is granted the exclusive power to “lay and collect Taxes, Duties, Imposts and Excises, and to pay the Debts and provide for the common Defence and General Welfare of the United States.”

In 1974, lawmakers passed the [Congressional Budget and Impoundment Control Act](#) in an effort to standardize the annual process for deciding tax and spending policy for each federal fiscal year and to prevent the executive

branch from making spending policy reserved to Congress. Among other things, it created the House and Senate Budget Committees and set timetables for each step of the budget process.

Perhaps most significantly, the 1974 Budget Act also created the Congressional Budget Office (CBO). This non-partisan agency has come to play a pivotal role in not just the budget process, but in the lawmaking process in general. The CBO issues economic forecasts, policy options, and other analytical reports, but it most significantly produces estimates of how much individual legislation would cost or save the federal government. Those estimates can and do often determine if legislation passes or fails.

The annual budget process is supposed to begin the first Monday in February, when the President is to present his proposed budget for the fiscal year that begins the following Oct. 1. This is one of the few deadlines in the Budget Act that is usually met.

After that, the action moves to Congress. The House and Senate Budget Committees each write their own “Budget Resolution,” a spending blueprint for the year that includes annual totals for mandatory and discretionary spending. Because mandatory spending (roughly two-thirds of the budget) is automatic unless changed by Congress, the budget resolution may also include “reconciliation instructions” to the committees that oversee those programs (also known as “authorizing” committees) to make changes to bring the cost of the mandatory programs in line with the terms of the budget resolution. The discretionary total will eventually be divided by the House and Senate Appropriations Committees between the 12 subcommittees, each responsible for a single annual spending (appropriations) bill. Most of those bills cover multiple agencies – the appropriations bill for the Department of Health and Human Services, for example, also includes funding for the Departments of Labor and Education.

After the budget resolution is approved by each chamber’s Budget Committee, it goes to the House and Senate floor, respectively, for debate. Assuming the resolutions are approved, a “conference committee” comprised of members from each chamber is tasked with working out the differences between the respective versions. A final compromise budget resolution is supposed to be approved by both chambers by April 15 of each year. ([This rarely happens.](#)) Because the final product is a resolution rather than a bill, the budget does not go to the President to sign or veto.

The annual appropriations process kicks off May 15, when the House may start considering the 12 annual spending bills for the fiscal year that begins Oct. 1. By tradition, spending bills originate in the House, although sometimes, if the House is delayed in acting, the Senate will take up its own version of an appropriation first. The House is supposed to complete action on all 12 spending bills by June 30, in order to provide enough time to let the Senate act, and for a conference committee to negotiate a final version that each chamber can approve by October 1.

That October 1 deadline is the only one with consequences if it is not met. Unless an appropriations bill for each federal agency is passed by Congress and signed by the President by the start of the fiscal year, that agency must shut down all “non-essential” activities funded by discretionary spending until funding is approved. Because Congress rarely passes all 12 of the appropriations bills by the start of the fiscal year (the last time was in 1996, for fiscal year 1997), it can buy extra time by passing a “continuing resolution” (CR) that keeps money flowing, usually at the previous fiscal year’s level. CRs can last as little as a day and as much as the full fiscal year and may cover all of the federal government (if none of the regular appropriations are done) or just the departments for the unfinished bills. Congress may, and frequently does, pass multiple CRs while it works to complete the appropriations process.

While each appropriations bill is supposed to be considered individually, to save time (and sometimes to win needed votes), a few, several, or all the bills may be packaged into a single “omnibus” measure. Bills that package only a handful of appropriations bills are cheekily known as “minibuses.”

Meanwhile, if the budget resolution includes reconciliation instructions, that process proceeds on a separate track. The committees in charge of the programs requiring alterations each vote on and report their proposals to the respective budget committees, which assemble all of the changes into a single bill. At this point, the budget committees’ role is purely ministerial; it may not change any of the provisions approved by the authorizing committees.

Reconciliation legislation is frequently the vehicle for significant health policy changes, partly because Medicare and Medicaid are mandatory programs. Reconciliation bills are subject to special rules, notably on the Senate floor, which include debate time limitations (no filibusters) and restrictions on amendments. Reconciliation bills also may not contain provisions that do not pertain directly to taxing or spending.

Unlike the appropriations bills, nothing happens if Congress does not meet the Budget Act’s deadline to finish the reconciliation process, June 15. In fact, in more than a few cases, Congress has not completed work on reconciliation bills until the calendar year AFTER they were begun.

A (Very Brief) Explanation of the Regulatory Process

Congress writes the nation’s laws, but it cannot account for every detail in legislation. So, it often leaves key decisions about how to interpret and enforce those laws to the various executive departments. Those departments write (and often rewrite) rules and regulations according to a very stringent process laid out by the 1946 [Administrative Procedure Act \(APA\)](#). The APA is intended to keep the executive branch’s decision-making transparent and to allow public input into how laws are interpreted and enforced.

Most federal regulations use the APA’s “informal rulemaking” process, also known as “notice and comment rulemaking,” which consists of four main parts:

- Publication of a “Notice of Proposed Rulemaking (NPRM)” in the [Federal Register](#), a daily publication of executive branch activities.
- Solicitation to the public to submit written comments for a specific period of time (usually from 30 to 90 days).
- Agency consideration of public reaction to the proposed rule; and, finally
- Publication of a final rule, with an explanation including how the agency took the public comments into account and what changes, if any, were made from the proposed rule. Final rules also include an effective date, which can be no less than 30 days but may be more than a year in the future.

In situations where time is of the essence, federal agencies may truncate that process by issuing “interim final rules,” which can take effect even before the public is given a chance to comment. Such rules may or may not be revised later.

Not all federal interpretation of laws uses the APA’s specified regulatory process. Federal officials also distribute guidance, agency opinions, or “statements of policy.”

Future Outlook

Given how fragmented health policy is in both Congress and the executive branch, it should not be a surprise that major changes are difficult and rare.

Add to that an electorate divided over whether the federal government should be more involved or less involved in the health sector, and huge lobbying clout from various interest groups whose members make a lot of money from the current operation of the system, and you have a prescription for inertia.

One potential wildcard—in June of 2024, [the Supreme Court overturned a 40-year-old precedent, known as “Chevron deference,”](#) that gave the benefit of the doubt in interpreting ambiguous laws passed by Congress to federal agencies rather than judges. Overturning Chevron will likely make it easier for outsiders to challenge federal agency actions, but it will be some time before the full ramifications become clear.

Another problem is that when a new health policy can dodge the minefield of obstacles to become law, it almost by definition represents a compromise that may help it win enough votes for passage, but is more likely to complicate an already byzantine system further.

Unless the health system completely breaks down, it seems unlikely that federal policymakers will be able to move the needle very far in either a conservative or a liberal direction.

Resources

- [FAQs on Health Spending, the Federal Budget, and Budget Enforcement Tools](#)
- [Medicare 101](#)
- [Medicaid 101](#)
- [The Affordable Care Act 101](#)
- [Employer-Sponsored Health Insurance](#)
- [The Regulation of Private Insurance](#)
- [The U.S. Government and Global Health](#)
- [The U.S. Congress and Global Health: A Primer](#)

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