

Overview of the U.S. Health Care System

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INTRODUCTION

The U.S. health care system is the subject of much polarizing debate. At one extreme are those who argue that Americans have the “best health care system in the world”, pointing to the freely available medical technology and state-of-the-art facilities that have become so highly symbolic of the system. At the other extreme are those who berate the American system as being fragmented and inefficient, pointing to the fact that America spends more on health care than any other country in the world yet still suffers from massive uninsurance, uneven quality, and administrative waste.

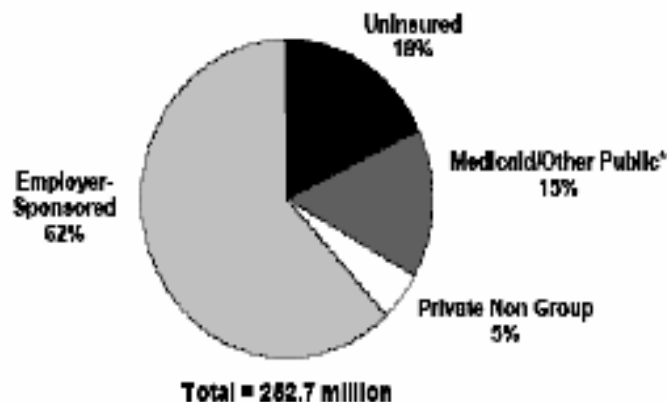
Understanding the debate between these two diametrically opposed viewpoints requires a basic understanding of the structure of the U.S. health care system. This primer will explain the organization and financing of the system, as well as place the U.S. health care system in a greater international context.

ORGANIZATION OF U.S. HEALTH CARE SYSTEM

As with all other countries, there are both private and public insurers in the U.S. health care system. What is unique about the U.S. system in the world is the dominance of the private element over the public element.

In 2003, 62% of non-elderly Americans received private employer-sponsored insurance, and 5% purchased insurance on the private non group (individual) market. 15% were enrolled in public insurance programs like Medicaid, and 18% were uninsured. Elderly individuals aged 65 or over are almost uniformly enrolled in Medicare.¹

Health Insurance Coverage of the Nonelderly Population, 2003



Notes: *Medicaid/Other Public includes Medicaid, S-CHIP, other state programs, Medicare and military-related coverage.
SOURCE: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of the March 2004 Current Population Survey.

Public Health Insurance

- Medicare²
 - Basics: Medicare is a federal program that covers individuals aged 65 and over, as well as some disabled individuals.
 - Administration: Medicare is a single-payer program administered by the government; single-payer refers to the idea that there is only one entity (the government) performing the insurance function of reimbursement.
 - Financing: Medicare is financed by federal income taxes, a payroll tax shared by employers and employees, and individual enrollee premiums (for parts B and D).
 - Benefits: Medicare Part A covers hospital services, Medicare Part B covers physician services, and Medicare Part D offers a prescription drug benefit. [Medicare Part C refers to Medicare Advantage – HMO's that administer Medicare benefits].
 - There are many gaps in Medicare coverage, including incomplete coverage for skilled nursing facilities, incomplete preventive care coverage, and no coverage for dental, hearing, or vision care. Because of this, the vast majority of enrollees obtain supplemental insurance. Overall, seniors pay about 22% of their income for health care costs despite their Medicare coverage.
- Medicaid³
 - Basics: Medicaid is a program designed for the low-income and disabled. By federal law, states must cover very poor pregnant women, children, elderly, disabled, and parents. Childless adults are not covered, and many poor individuals make too much to qualify for Medicaid.
 - States have the option of expanding eligibility if they so choose. For example, states can choose to increase income eligibility levels.
 - Administration: The states and the District of Columbia are responsible for administering the Medicaid program; as such, there are effectively fifty-one different Medicaid programs in the country.
 - Financing: Medicaid is financed jointly by the states and federal government through taxes. Every dollar that a state spends on Medicaid is matched by the federal government at least 100%. In poorer states, the federal government matches each dollar more than 100%. Overall, the federal government pays for 57% of Medicaid costs.
 - Benefits: Medicaid offers a fairly comprehensive set of benefits, including prescription drugs. Despite this, many enrollees have difficulty finding providers that accept Medicaid due to its low reimbursement rate.
- Other public systems⁴
 - S-CHIP: The State Children's Health Insurance Program (S-CHIP) was designed in 1997 to cover children whose families make too much money to qualify for Medicaid but make too little to purchase private health insurance. S-CHIP and Medicaid often share similar administrative and financing structures.
 - VA: The Veteran's Administration is a federally administered program for veterans of the military. Health care is delivered in government-owned VA

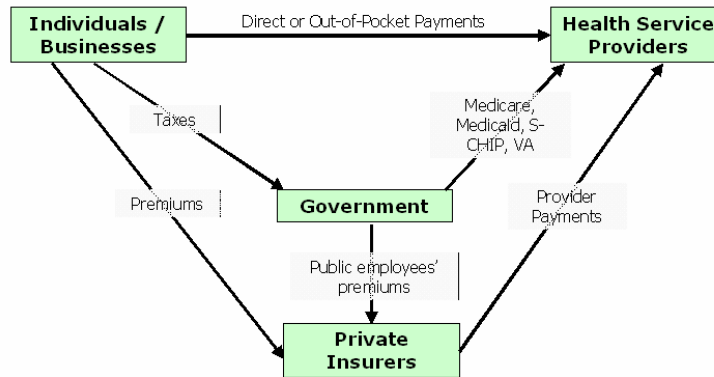
hospitals and clinics. The VA is funded by taxpayer dollars and generally offers extremely affordable (if not free) care to veterans.

Private Health Insurance

- Employer-sponsored insurance⁴
 - Basics: Employer-sponsored insurance represents the main way in which Americans receive health insurance. Employers provide health insurance as part of the benefits package for employees.
 - Administration: Insurance plans are administered by private companies, both for-profit (e.g. Aetna, Cigna) and non-for-profit (e.g. Blue Cross/Blue Shield).
 - A special case is represented by companies that are “self-insured” – that is, they pay for all health care costs incurred by employees directly. In this case, the company contracts with a third party to administer the health insurance plan. Self-insured companies tend to be larger companies such as General Motors.
 - Financing: Employer-sponsored insurance is financed both through employers (who usually pay the majority of the premium) and employees (who pay the remainder of the premium). In 2005, the annual private employer-sponsored insurance premiums averaged \$4,024 for single coverage and \$10,880 for a family of four.⁵
 - Benefits: Benefits vary widely with the specific health insurance plan. Some plans cover prescription drugs, while others do not. The degree of cost-sharing (co-pays and deductibles) varies considerably.
- Private non-group (individual market)⁴
 - Basics: The individual market covers part of the population that is self-employed or retired. In addition, it covers some people who are unable to obtain insurance through their employer. In contrast to the group market (employment-based insurance), the individual market allows health insurance companies to deny people coverage based on pre-existing conditions.
 - Administration: The plans are administered by private insurance companies.
 - Financing: Individuals pay an insurance premium out-of-pocket for coverage. Risk in the individual market depends only on the health status of the individual, in contrast to the group market, in which risk is spread out among multiple individuals. As such, low-risk, healthy patients will have a low premium, whereas the opposite is true for high-risk, sick patients.
 - Benefits: Benefits vary widely with the specific health insurance plan.

FINANCING OF THE U.S. HEALTH CARE SYSTEM

The financing of health care centers around two streams of money: the collection of money for health care (money going in), and the reimbursement of health service providers for health care (money going out). In the United States, the responsibility for these two functions is shared by private insurance companies as well as the government, both of which are known in policy terms as “payers.” As such, the United States can be thought of as a “multi-payer” system.



- Individuals and businesses
 - **Taxes:** Both individuals and businesses pay income taxes to the government. In addition, there is a payroll tax on employers and employees to finance Medicare.
 - **Premiums:** Businesses pay all or most of the premium for employer-based insurance for employees, and employees pay the remainder. On the individual market, individuals pay for all premiums out of pocket. Employer-based insurance premiums and individual insurance premiums are collected by private insurers.
 - **Direct or out-of-pocket payments:** This is a direct payment to a provider for health care services (e.g. a co-payment).
- Government
 - **Medicare, Medicaid, S-CHIP, and the VA:** The government uses money generated from taxes to reimburse providers who take care of patients enrolled in these programs.
 - **Public employees' premiums:** The government also uses tax dollars to pay private insurers a health insurance premium for federal employees and other public employees.
 - **Tax subsidy:** There is a tax subsidy of employer-based insurance (not shown in the graph) that represents a major cost to the government (on the order of \$100 billion). Employees receive health insurance benefits as tax-free compensation, and employers are able to deduct health insurance benefits as a cost of doing business. [Since employers are only taxed on profits, defined as any income above the cost of doing business, being able to deduct health insurance benefits as a cost of doing business is a tax subsidy for employers].
- Private insurers
 - Private insurers accept premiums from individuals, businesses, and the government. In turn, they reimburse providers for taking care of patients with private insurance.
- Health service providers
 - Providers (doctors, allied health professionals, hospitals, and other health care facilities) take care of individuals. They are reimbursed for their services by private insurers and the government.

In 2002, government expenditures accounted for 44.9% of healthcare costs in the United States, and private expenditures accounted for the remaining 55.1%.⁶ The U.S. spent \$1.7 trillion on health care expenditures in 2003. Of the \$1.7 trillion used on health care, the majority went to hospital care and physician/clinical services.

THE U.S. HEALTH CARE SYSTEM IN AN INTERNATIONAL CONTEXT

[Note: This is taken directly from “OECD Health Data 2005: How Does the United States Compare”⁷].

Health spending and financing

The United States spent 15% of its GDP on health care in 2003, the highest percentage in the OECD (an organization of industrialized countries). The average percentage of GDP spent on health care in OECD countries was 8.6%. The United States also spends more on health care per capita than any other OECD country. In 2003, total health spending per capita was \$5,635 US dollars (adjusted for purchasing power parity), more than twice the OECD average of \$2,307 US dollars.

Between 1998 and 2003, health spending per capita in the United States increased in real terms by 4.6% per year on average, a growth rate comparable to the OECD average of 4.5% per year.

The public sector is the main source of health funding in all OECD countries, except for the United States, Mexico and Korea. In the United States, 44% of health spending is funded by government revenues, well below the average of 72% in OECD countries. In the United States, private insurance accounts for 37% of total health spending, by far the largest share among OECD countries. Canada, France, and the Netherlands also have a relatively large share of funding coming from private insurance (more than 10%).

Resources in the health sector (human, physical)

- In 2002, the United States had 2.3 practicing physicians per 1000 population, below the OECD average of 2.9 per 1000 population.
- There were 7.9 nurses per 1000 population in the United States in 2002, below the OECD average of 8.2 per 1000 population.
- The number of acute care hospital beds in the United States in 2003 was 2.8 per 1000 population, below the OECD average of 4.1 beds per 1000 population.

Health status and risk factors

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the United States, life expectancy at birth increased by 7.3 years between 1960 and 2002, which is less than the increase of 14 years in life expectancy in Japan, or of 8.4 years in Canada. In 2002/3, life expectancy in the United States stood at 77.2 years, below the OECD average of 77.8 years. Japan, Iceland, Spain, Switzerland and Australia were among the top 5 countries registering the highest life expectancy among OECD countries.

Infant mortality rates in the United States have fallen greatly over the past few decades, but not as much as in most other OECD countries. In 2002, the infant mortality rate in the U.S. was 7 deaths per 1,000 live births, above the OECD average of 6.1. Among OECD countries, infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway), which all have infant mortality rates below 3.5 deaths per 1,000 live births.

In the United States, the proportion of smokers among adults has fallen from 33.5% in 1980 to 17.5% in 2003, the lowest rate among OECD countries along with Canada and Sweden. In the United States, the obesity rate among adults (30.6% in 2002) is the highest in OECD countries, followed by Mexico (24.2% in 2000) and the United Kingdom (23% in 2003).

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