BACKGROUND BRIEFING ON US HEALTHCARE

By Ben Irvine (2002)

This briefing is based on a commissioned report and presentation to the Health Policy Consensus Group, by Grace-Marie Turner.

The health sector in the United States is diverse and is characterised by a mix of public and private funding and provision, as such, it is not governed by a single philosophy. In both the private and public sectors, medical services generally are regarded as high quality. First, we look at the various public programmes, and second the private programmes; thereafter we consider recent developments in US health care, and the lessons to be learned for the UK.

Public sector health programmes

The US spends 5.7 per cent GDP of taxpayer income on health care, representing 44.5 per cent of total expenditure on healthcare (OECD Health Data, 2001). Two public healthcare programmes are dominant in the United States, Medicare and Medicaid, and both were created in 1965. Medicare is the federal government's health programme primarily serving Americans who are over age 65. Medicaid is a joint federal-state programme designed primarily to finance health care for the poor. Both provide care for the disabled. Together, Medicare and Medicaid cover more than 80 million Americans. Medicare beneficiaries and Medicaid recipients are entitled to outpatient medical care from physicians and hospital care from the same medical professionals who provide health care to individuals with private health insurance.

Medicare

In 2001, there were 39 million Medicare beneficiaries, including 34 million senior citizens and five million disabled.[1] The $237 billion cost of the programme was paid by taxes on today's workers, premium contributions by beneficiaries, and some general revenue funds.

Pensioners can participate in Medicare regardless of their income. Most beneficiaries have paid payroll taxes into the programme during their working years, which entitles them to participate in the Medicare hospitalisation programme when they reach age 65 (called Medicare A). At age 65, they also pay a monthly premium of $54 a month to receive coverage for physician services and preventive care (Medicare B).[2] Eighty-six per cent of elderly Medicare beneficiaries receive their care through these two programmes. To give them protection against some of the health care expenses that Medicare does not cover, many Medicare A and B beneficiaries purchase additional private insurance, called **Medigap policies**, which provide supplemental Medicare coverage.

Medicare Part C was added to the programme in 1997. Also known as **Medicare+Choice,** the remaining 14 per cent of elderly Medicare beneficiaries, 5.7 million Americans, choose to enroll. It gives beneficiaries a choice of receiving their health care through a number of participating private health plans, including full-service Health Maintenance Organizations (HMOs).

Medicare is very popular with pensioners and politicians, despite growing problems with the programme's benefit structure and looming funding shortfalls. Perhaps this is because, unlike the great majority of working Americans with private health insurance, Medicare beneficiaries are free to seek medical care wherever they choose – a so-called "fee-for-service" model.

Medicaid

Medicaid, was designed to provide health care to the poor. In 2001, 40 million persons received Medicaid benefits, with projected costs of $124 billion in federal payments and $95 billion in state

[1] Congressional Budget Office Testimony of Dan L. Crippen, Director. "Prescription Drugs and Medicare Financing," presented before the Committee on Finance, United States Senate on March 22, 2001.
[2] Centers for Medicare and Medicaid Services. Medicare Premium Amounts for 2002. From www.medicare.gov, the official U.S. website for Medicare.

payments.[3] The costs of the programme are financed primarily through federal and state general revenue funds. As a primary funding source, the individual states have a great deal of leeway in designing their Medicaid programmes. Accordingly, there is great variation across the country over who is eligible for Medicaid, what services are covered, and how much doctors and hospitals will be paid for treating Medicaid patients.

While Medicaid recipients theoretically have access to a very rich package of health services and are entitled to receive healthcare services through the same public and private hospitals that serve the general public, their access to private physicians often is limited by Medicaid's commonly very low payment rates to private physicians. For example, the average reimbursement from Medicaid for a physician office visit in the state of Rhode Island is $13.40 – which cannot even begin to cover costs.[4] That means that in reality, a hospital A&E is often the Medicare patient's only sure source of access to that care.

Community Health Programmes

Community-based health centres, are private, not-for-profit facilities that provide high quality, cost-effective and comprehensive primary and preventative care to the uninsured and medically underserved. More than 11 million patients utilise these programmes. Federal grants, Medicaid and Medicare payments, state and local grants, private insurance payments, patient fees, foundation grants, and private donations fund community health centres. Patient cost-sharing is means-tested on a sliding fee scale according to income. The annual budget for these community-based health programmes is $14 billion.[5]

Private sector health programmes

Seventy-two per cent of Americans, or 200 million people, were covered by private health insurance in the year 2000.[6] Until the 1990s, most private health insurance coverage was provided through a fee-for-service model that allowed patients to visit the doctor or hospital of their choice. As health insurance costs began to rise in the 1990s, many employers hired health plans to "manage" their employees' health care by controlling access to care and lowering costs. An ICR/Associated Press poll shows that 88 per cent of Americans are satisfied with the quality of their health care, but they are dissatisfied with managed care and other bureaucratic barriers.

Managed Care

Managed care puts administrators and designated "gatekeepers" in charge of guiding patients through a health care network, with a goal of managing costs. Patients are often required to check with their health plan for approval before visiting a specialist or receiving a medical procedure.

---

[3] United States General Accounting Office. *Medicaid: State Efforts to Control Improper Payments Vary*. Report to the Chairman, Committee on Energy and Commerce, House of Representatives. June 2001.

[4] HireHealth.com: http://www.hirehealth.com/ci/servlet/com.ci.service.NewsResearch?VIEW_DETAIL=1&NEWS_ID=6246

[5] National Association of Community Health Centers.

[6] The number of people covered by various health care programmes described in this programme or who are may add up to more than the total population of the United States because some people have coverage through more than one programme.

Today, nearly nine of out ten American workers or their dependents are in some type of managed health care plan.[7] Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are examples of such managed care arrangements. HMOS, which have a current enrollment of 79 million, generally provide care through hospitals and clinics that the plans own, with physicians, nurses, and other personnel employed by the HMO. PPOs are more popular, with 98 million enrolled. PPOs are networks of doctors and hospitals that have agreed to treat participants in these plans for reduced fees based upon pre-negotiated contracts.

While employers instituted managed care to control rising health costs, many Americans have become frustrated with a system that essentially places barriers between them and the medical care they want and/or need. Alas, they are limited in their options for action.

Employer-Provided Health Insurance with Tax Benefits

Originally offered as a non-wage benefit to attract workers, employment-based health insurance is by far the dominant vehicle through which the majority of Americans receive health care; today, 64 per cent, or 177 million, receive their coverage through the workplace .[8] Americans receive a generous tax benefit if their employer purchases their health insurance policy for them. The full value of the policy, which may be as much as $10,000 a year, is protected from income and payroll taxes. This subsidy creates a strong incentive for people to obtain private health insurance through the workplace in order to take advantage of this tax preference.

Generally employers pay most of the health insurance premium and require employees to pay a share, which is usually deducted from their salary. Some employers may not require employees to pay any of the premiums, while others may require employees to pay half or more.

There are thousands of variations of private health insurance policies around the country, depending upon what employers can afford and what employees have negotiated. Currently 60 per cent of employers who offer health insurance benefits offer their employees a choice of health plans.[9] If employers offer a choice of plans, they usually provide three to five options.[10] These options usually include a traditional fee-for-service plan, a closed-model Health Maintenance Organization, or a Preferred Provider Organization with pre-negotiated discounted prices for selected doctors and hospitals. However, many workers who get their health coverage at work do not have a choice. Employees either take the plan their employer offers, or they go without coverage.

Healthcare Purchasing Co-operatives: The Federal Employees Health Benefits Program

Envisioned by Alain Enthoven, health care purchasing co-operatives (also known as purchasing pools and alliances) are public or private organisations which secure health insurance coverage for the workers of all member employers. The goal of these organisations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, to reduce the administrative costs of buying, selling and managing insurance policies.

The Federal Employees Health Benefits Program (FEHBP) which began operation in 1960 is a purchasing co-operative. Today it provides insurance to some nine million federal civilian employee and retiree policy holders, and their families. The US federal government typically pays 72 per cent of the actual premium of each person's chosen plan. Employees pay the difference via payroll deductions. All insurers must community rate – this means that a retired person pays the same as an 18-year old trainee. Insurers must also accept all applicants regardless of pre-existing conditions.

---

[7] Employee Benefits Research Institute. *The 2001 Health Confidence Survey* Summary of Findings; 1-9.
[8] Mills Robert J. *Health Insurance Coverage: 2000*. U.S. Census Bureau Current Population Reports 2001: 60-215.
[9] *The 2002 Harris Interactive Survey* of employees in employer-sponsored insurance.
[10] *The 2002 Harris Interactive Survey* of employees in employer-sponsored insurance showed 57per cent of employees who had a choice of plans had between three to five options.

Owing to the size of the federal work force, federal workers have their choice of a wide range of health insurance plans that enable employees to choose the benefits package that best suits their particular health care needs and budgets; workers generally have a choice of about 20 health plans in any region of the country.

To meet the minimum standard for accreditation, plans must fulfil criteria including access for patients, coordination of care, and medical decision making which adheres to acceptable standards of practice. Plans are rated for consumers by the 5-star system under categories like access and service, and qualified providers. This provides consumers with the information to make an informed choice. Because choice and competition are hallmarks of the programme, the FEHBP reports one of the highest levels of satisfaction of any health care programme in the country.[11]

Individual Health Insurance – with no tax benefits

There is also an individual insurance market for those who do not participate in or are not offered employer-sponsored group plans. However, individuals face adverse tax consequences if they want to buy health insurance on their own outside the workplace; if they purchase health insurance on their own, most must use after-tax dollars to pay for the policy. The individual market is highly regulated by the states with onerous benefit mandates and restrictions that drive up the cost of premiums.

The Uninsured and the Unofficial Safety Net

In 2000, an estimated 38 million Americans did not have health insurance.[12] Some of the uninsured are moving between jobs, and with health insurance so closely tied to the workplace in the United States, their job transitions often mean that they and their families will have periods without health coverage. Others are higher income earners or young people who are simply deciding to go without insurance. Those who do not have the option of obtaining health insurance through their jobs are faced with the prospect of purchasing coverage in the individual market, which in many states can be very expensive. They decide instead to spend that money on food, housing, transportation, and other necessities.

Being uninsured by no means indicates that people are barred from receiving medical care. Any hospital in the United States that accepts Medicare or Medicaid patients is legally bound to provide medical treatment and stabilize any patient who presents a medical problem, whether or not that patient can pay the bill. Hospitals that treat a substantial number of poor patients, including those on Medicaid, Medicare, or without health insurance, receive a Disproportionate Share payment from the federal government to help compensate them. The theory is these hospitals have higher operating costs because poor patients are generally sicker.

The uninsured are also protected by an unofficial safety net and receive medical care through additional programmes, such as joint private-public sector health programmes, including free clinics and community health centres described earlier. But the uninsured often do wait until later stages of illnesses to get the care they need. And they also live in fear that they or their family members will get sick or have an accident and that the bills could bankrupt the family.

Future / Reforms of US Health Care

US healthcare is the most expensive in the world and there are widespread concerns about its viability, especially as so many people remain uninsured. Moreover, many are coming to realise that pouring additional millions of dollars into malfunctioning systems only perpetuates their problems.[13]

---

[11] *A Blueprint For New Beginnings: A Responsible Budget for America's Priorities.* U.S. Government Printing Office. Washington 2001. http://www.whitehouse.gov/news/usbudget/blueprint/bud13.html

[12] United States Census Bureau. *Current Population Survey* March 2000 and 2001.

[13] Johan Hjertqvist. *Blair Repeats the Stockholm Sea Change,* Fact Sheet. The Timbro Health Unit. Stockholm, Sweden, May 2002.

Helping the uninsured through refundable tax credits: One of the most promising new programmes involves providing direct subsidies to the uninsured to purchase private health insurance. The mechanism that is supported by President George W. Bush and many leaders in Congress involves providing tax credits to individuals to help offset the cost of purchasing health insurance in the individual market. These tax credits would provide financial help to those who make too much to qualify for Medicaid and too little to receive good health insurance at work. At present, workers with incomes of about $25,000 a year are least likely to receive any help in purchasing health insurance.

Those who qualify for this proposed plan would receive certificates that could be used like cash to purchase coverage, so that the eligible individual need only pay the difference between the insurance premium and the tax credit.[14] Tax credits would also empower consumers to make their own choices of the health coverage that best suits them and their families while controlling costs through competition in the private marketplace.

Empowering Consumers: Many employers are searching for new and more creative solutions to engage consumers in the decision-making process about their health coverage and to provide incentives for them to use services wisely. Some of these options include Defined Contribution Plans and Medical Spending Accounts.

In a **Defined Contribution Plan (DCP)**, employers may provide a specified amount of money toward the employee's health insurance coverage. For example, employers may put part of the money they are spending on health insurance premiums into a spending account that employees can use for routine medical bills without anyone micromanaging their choices. The company also purchases catastrophic coverage to protect employees against the costs of large medical bills. By putting consumers in charge of their health insurance, defined contribution plans allow them to be more aware of the cost of health insurance coverage and medical services. This, combined with a more competitive marketplace created by consumers shopping for plans, could be the key to reducing medical price inflation.

Congress passed legislation in 1997 creating the **Medical Savings Accounts (MSA)** option, but made it available only to individuals and workers in small firms. Like the DCP plan described above, an MSA couples a high-deductible insurance plan with a health spending account for routine healthcare expenses. While the spending account pays first-dollar coverage, the balance in the account is allowed to rollover tax-free from year to year, encouraging savings and wiser healthcare utilisation. The MSA is built on the theory that consumers are more cautious when spending their own money than when they spend what they perceive to be their employer's or insurance company's money on health services.

Onerous Regulations and Mandates

These new healthcare approaches that engage the consumer have come up against state and federal regulations that limit how flexible they can be in competing on price and benefits. Health insurance regulations in many states tell insurers what benefits they must offer, to whom (obligation to contract), and what prices they may charge (community rating). Designed with solidarity in mind, these regulations have harmed the individual insurance market by pushing up premiums and have retarded attempts at innovative reform efforts.

Healthcare Outcomes

It is argued that innovation in equipment and procedures have allowed survivor rates to increase significantly in major diseases such as cancer and heart disease. For example, in the United States:

---

[14] Council of Economic Advisors *Report to the President, 2002.* http://w3.access.gpo.gov/usbudget/fy2003/pdf/2002_erp.pdf

- The 5-year relative survival rate of all types of cancer has increased from 50 per cent in 1974 to 62 per cent in 1997.[15]
- The five-year relative survival rate for localised breast cancer has increased from 72 per cent in the 1940s to 96 per cent today.[28]
- Over the past 20 years, the survival rate for prostate cancer has increased from 67 per cent to 96 per cent.[28]
- The one-year survival rate for lung cancer has increased from 34 per cent in 1975 to 41 per cent in 1997.[28]
- From 1989 to 1999, death rates from cardiovascular disease declined 15.6 per cent.[16]
- Death rates for congenital cardiovascular defects declined 31.5 per cent from 1989 to 1999.[29]

Healthcare financial inputs in the US might lead observers to expect the best outcomes in the world. But, with the exception of cancer survival, overall outcomes are comparatively poor, often ranking behind European countries that spend much less than half the amount of US$ PPPs on healthcare.

Lessons for the UK

- The US health system is inequitable. Those who receive health insurance at work receive a generous tax break worth more than $130 billion a year. Meanwhile, many usually low-paid workers find it difficult to obtain affordable coverage because their employer does not include health insurance as a workplace benefit.
- The United States spends a large proportion of its Gross Domestic Product (GDP) on health services, yet *many Americans are uninsured*. This leads to criticism from other countries that there is little to be learned from the United States regarding health care. This is a short-sighted response that ignores that widespread recognition in the US that changes are essential to bring the uninsured into the system, and that many policy initiatives are being considered to do just that.
- Employment-based insurance does not encourage price-consciousness – apart from their co-payments and deductibles, individuals have little incentive to economise
- In practice, most consumers are unable actively to shop around for plans. If they do not like the health insurance and restrictions offered by their employers, they face adverse tax consequences if they want to buy health insurance on their own outside the workplace.
- Because the majority of health care in the United States is delivered through private-sector programmes, the system overall is better than most in encouraging continual *innovation and new technology*. For example, the strength of the U.S. health sector is evident through pharmaceutical innovation and new medical techniques and technologies, rewarded by policies that, for the most part, value and pay for these advances.
- In addition, there is more *innovation in health care financing and coverage* than in countries where the majority of the health sector is controlled through government programmes; virtually all of the innovative ideas in U.S. health policy are aimed at engaging market forces and consumer power in reshaping the system – whether in private, employment-based plans or public plans like Medicare.
- Because of its diversity, the U.S. health sector is not governed by a single philosophy, but as in most other sectors of the economy, the *more involvement there is from governmen*t programmes or private insurance, the *more strings are attached* to the provision and price of health care. Many of the problems U.S. public programmes experience, especially Medicare and Medicaid, are similar to those in government run healthcare systems in the United Kingdom and other industrialized nations.
- By offering lower reimbursements, public programmes can lead to a demonstrably lower quality of care.

[15] American Cancer Society, *Facts and Figures 2002*.
[16] American Heart Association, *2002 Heart and Stroke Statistical Update.*

- Perhaps the most important lesson for the UK is that spending more does not guarantee better health outcomes. Indeed, pouring millions more dollars into malfunctioning systems only perpetuates their problems.[17]

[17] Johan Hjertqvist. *Blair Repeats the Stockholm Sea Change,* Fact Sheet. The Timbro Health Unit. Stockholm, Sweden, May 2002.