

Overview of the U.S. Health Sector

By Grace-Marie Turner
President, Galen Institute

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The health care sector in the United States is unique among developed countries in its nearly equal mix of private and public sector programs, and it is necessarily diverse to respond to the very different needs and demands of more than 300 million people living in a large country with many ethnic, racial, and religious backgrounds.

This paper will provide a brief overview of the public and private sector programs in the U.S. health sector and the populations they serve and will describe policy proposals being considered to cover the uninsured through market-based solutions.

A Profile of the Health Sector in the United States

Health spending in the United States is nearly equally divided between the public and private health sectors. In 2007, U.S. health care expenditures totaled more than \$2.2 trillion, representing 16% percent of the gross domestic product. Of the total, 46 percent, or more than \$1 trillion, was spent through public programs, and more than \$1.2 trillion, or 54 percent, was through private spending.¹ Both the public and private sectors are facing significant pressures for change, largely because of rising costs.

Tax revenues provide the largest share of funding for public programs. The great majority of those with private health insurance receive their coverage through the workplace, with a combination of employer and employee payment for premiums. Other individuals and families purchase their own insurance policies in the private market. Philanthropic organizations, including churches and charitable organizations, also provide funding to support care that is delivered through hospitals, clinics, and other facilities.

PUBLIC SECTOR PROGRAMS

Two taxpayer-supported health care programs are dominant in the United States: Medicare and Medicaid. Both were created by Congress in 1965. Medicare is the federal government's health program serving Americans who are over age 65 and the disabled of any age. Medicaid is a joint federal-state program designed primarily to finance health care for the poor. Together, Medicare and Medicaid provide health services to more than 104 million Americans.²

The newest government health program is the State Children's Health Insurance Program that provides health coverage to more than seven million children in families whose parents earn too much to qualify for Medicaid but who can't afford private insurance.³ In addition, there are more than one thousand community health centers providing free or low-cost care to lower-income Americans, plus federal programs for specific populations, such as veterans and Native Americans, and many state and local health care programs.

Medicare overview

In 2008, there were 45 million beneficiaries of the Medicare program, including approximately 38 million elderly and 7 million disabled people.⁴ In 2009, the Medicare program is projected to cost \$477 billion, financed by a combination of taxes on today's workers, premium contributions by beneficiaries, and general revenue funds.⁵

In addition to virtually all elderly people, some disabled people also qualify for Medicare coverage. If a person is under age 65 but is disabled and has been receiving disability benefits under Social Security for two years, he or she also is eligible for Medicare.

Medicare beneficiaries receive the health care services allowed by the programs through the same public and private hospitals serving the general public, but doctors, hospitals, and other providers are paid at government-determined rates based upon complex, government-determined fee schedules.

Medicaid overview

Medicaid is designed to provide health care to the poor and is jointly funded by the federal and state governments. States have some flexibility in designing their Medicaid programs but must abide by federal directives. In 2006, 59 million persons received Medicaid benefits, with projected costs reaching \$304 billion in combined federal and state payments.⁶ The costs of the program are financed almost exclusively through federal, state, and local general revenue funds.

Medicaid beneficiaries also are entitled to receive health care services through the same public and private hospitals that serve the general public. However, access to private physicians often may be functionally limited by Medicaid's often very low payment rates.

Political leaders regularly vote to expand the number of people who can participate in Medicaid. But to keep budgets from running out of control, states have put strict limits on Medicaid's payments to doctors and hospitals. For example, the average reimbursement from Medicaid for a physician office visit in a typical state is \$20⁷ while a private plan may pay \$50 to \$70 for the same visit.⁸

The functional result of this system of underpayment is that Medicaid patients often cannot find private physicians willing to see them and are forced to get both urgent and routine health care in hospital emergency rooms, which are required by law to treat them.

The State Children's Health Insurance Program provides coverage for an additional 7 million lower-income children.⁹ In addition, a number of other public programs provide health coverage for targeted groups, including the Veterans Health Administration, the Indian Health Service, and programs for active-duty and retired military personnel.

Private health insurance

More than 67 percent of Americans, or more than 200 million people, were covered by private health insurance in the year 2007.¹⁰ The majority of Americans with private health insurance received their coverage through the workplace – nearly 60 percent, or 177 million people.¹¹ This includes both active workers and people who receive retiree health coverage. An additional 27 million purchase

health insurance on their own in the private market, including 10 million who purchase supplementary Medicare policies.¹²

A wide variety of private insurance coverage options are available, including different networks of doctors and hospitals, along with many financing options. Employers generally negotiate which health plans will be offered to their employees, and sometimes, but not always, employees have a choice of several plans from which to choose. Some insurance policies may cover virtually all health care bills, but the monthly premiums are quite high. The average annual health insurance premium for a job-based policy for a family is \$12,680.¹³ Others may choose a higher-deductible policy with lower premiums.

One of the newest options is Health Savings Accounts (HSAs) which were created by Congress in 2003 to give people a different way of financing their health care. HSA holders can put tax-free money aside to pay for routine health expenses as long as they purchase a high-deductible health insurance to cover major medical bills. A large percentage of people initially purchasing HSAs were previously uninsured.¹⁴ They found the premiums for the high-deductible coverage generally to be lower, making the coverage more affordable. As of December of 2007, more than six million people were enrolled in health insurance plans that would make them eligible to make tax-free HSA contributions.¹⁵

In addition to new financing options, employers are creating a number of innovative programs to engage consumers as partners in managing their health care. Health information services, prevention and wellness incentives, price transparency, and chronic care and disease management all are being advanced by private companies in efforts to get prices down, keep quality up, and provide more value for health spending.

Americans value the greater access to physicians and other providers that private health insurance allows, but many would like to have more choices in their insurance coverage and health insurance that is more portable.¹⁶ Changes in federal tax policy have been recommended by a number of political leaders to achieve these goals, as we will describe later in this paper.

THE UNINSURED

In 2007, an estimated 45.7 million Americans did not have health insurance.¹⁷ While the numbers change, the profile of the uninsured remains quite constant.

The likelihood of someone having health insurance is closely tied to income, to employment status, and to whether the worker's job provides health insurance. According to U.S. Census Bureau data, the uninsured are primarily: 1) minorities, especially Hispanics, 2) lower and lower-middle income Americans; and 3) young adults between ages 18 and 24.¹⁸ The Census Bureau finds that the uninsured are most likely to be in families with annual incomes of less than \$25,000¹⁹ and to be employees of small businesses and their dependents.

Some of the uninsured are moving between jobs, and with health insurance so closely tied to the workplace in the United States, these job transitions often mean that workers and their families will have periods without health coverage. The United States is a particularly mobile society. Fifty-five million workers changed their employment status in 2007.²⁰

A 21st century solution would allow individuals to own and control their own health insurance and take it with them from job to job. A number of public policy initiatives are being considered in Washington and among the states that would allow greater portability of health insurance and direct subsidies for health insurance for those who need assistance in purchasing coverage. Advocates believe these measures will go a long way toward solving the problem of so many Americans being uninsured.

THE SAFETY NET

While the U.S. is often criticized for the large number of uninsured citizens, the full picture is more complex.

Being uninsured by no means indicates that people are barred from receiving medical care. Virtually anyone can receive care at a hospital or can pay bills directly to receive medical care at a doctor's office or medical institution, even though they may not have health *insurance*. The Emergency Medical Treatment and Active Labor Act requires that hospitals in the United States that accept

Medicare or Medicaid patients – i.e., virtually all of them – are legally bound to provide medical treatment to any patient who presents with a medical problem whether or not that patient can pay the bill. Billions of dollars in federal subsidies go to hospitals to compensate them for the free care they provide. Therefore, while millions of Americans do not have health insurance, it is a violation of federal law for the ill or injured to be denied care in times of medical need.

Therefore, the uninsured are protected by official and unofficial safety nets to receive medical care through:

- Hospital emergency rooms and other hospital admissions.
- Joint private-public sector health programs, including community health centers.
- Free clinics and health fairs operated by churches and other philanthropic organizations
- Charity care provided by physicians and hospitals.
- Private payments to doctors and hospitals.
- Care at private clinics located in pharmacies and other retail establishments and at the workplace.

As one example of alternative sources of care for the uninsured, the Bush administration doubled federal financing for community health centers, enabling the creation or expansion of 1,297 clinics in medically underserved areas. As a crucial component of the health safety net, these clinics provide a cost-effective alternative to hospital emergency rooms, where the uninsured and underinsured often seek care. For those in poor urban neighborhoods and isolated rural areas, including Indian reservations, the clinics provide basic services like prenatal care, childhood immunizations, asthma treatments, and cancer and other screening tests.²¹ The Obama administration has proposed additional funding to further expand community health centers.

In addition, a more detailed analysis of who the uninsured are shows that the problem is too complex to be solved by simply expanding government programs to cover an additional 46 million people. Nearly half of the uninsured are without coverage for four to six months, primarily because they are in transition between jobs. With health insurance so closely tied to the workplace in the U.S., people often are without health insurance as they move from one job to another and wait to qualify for health insurance at their new workplace.²² The number and percentage of people losing job-based coverage is increasing during the current economic downturn.

An estimated 14 million of the uninsured already are eligible for existing public programs, especially Medicaid and the State Children's Health Insurance Program, but are not enrolled.²³ Current legislative initiatives in Congress would expand access to these programs for millions more Americans.

Another 10 million are in the U.S. illegally and would present a special challenge in any health reform initiative.²⁴ An estimated 28 million make more than \$50,000 a year but do not purchase health insurance.²⁵ Fewer than 8 million want and need health insurance but have a difficult time obtaining it, either because they do not have jobs that offer health insurance or because they can't afford it or have health problems that make policies prohibitively expensive.²⁶

But the problem of the uninsured must be addressed. Too many of them wait until later stages of illnesses to seek care. Others live in fear that they or their family members will get sick or have an accident and that the bills could bankrupt the family. Clearly, policy changes are needed to fix the problem, and debate over solutions is an important policy agenda for the new Congress and Obama administration.

Challenges to the U.S. health care system

Four main problems in the health sector include: 1) the rising cost of insurance and medical care, 2) the large number of uninsured Americans, 3) balancing the demand for new and better medical technologies with cost, and 4) crushing paperwork and regulatory burdens.

1) **Health Spending.** Pressures are intense in both private and public sector health plans to manage costs. U.S. health spending grew by 6.1 percent in 2007. Premiums for private health insurance rose by 6 percent while spending for public programs increased by 6.4 percent in 2007.²⁷ Medicaid is receiving particular attention because the program is consuming nearly one-third of state government budgets,²⁸ threatening benefit cuts, higher taxes, or reduced spending on other programs.

2) **Uninsured.** The large number of uninsured is a problem not only for these individuals and families without health coverage, but also for society as a whole. Those who do not have predictable access to medical treatment often wait until an illness becomes acute before seeking treatment. Not only is the cost of treatment

then generally higher, but also the cost is more likely to be borne by the taxpayer through any of the various channels hospitals and doctors are compensated. Most importantly, the person may suffer long-term consequences of going without needed medical treatment.

3) **Technology.** Demands for new technologies and the latest pharmaceutical treatments are growing, and consumers may face bureaucratic and financial barriers to the medical care they want and need for themselves and their families. As new diagnostic and surgical technologies and more miracle drugs are discovered, developed, and introduced, the pressures will become even more intense.

4) **Paperwork.** Nurses, physicians, hospitals and other medical providers are burdened by significant paperwork and regulatory requirements for both private and public sector health programs.²⁹ This adds significant costs to the health sector, both in time consumed by paperwork and regulatory compliance. In addition, because the system is still largely reliant on paper and lacks interoperable electronic medical records, duplications of diagnostics and unnecessary treatments are prevalent.

The search for solutions to the problem of millions of uninsured

The search for solutions to the problems in the health care system in the United States has generated decades of national debate.

Many experts in the health policy community believe that modernizing the financing system of health care is the crucial first step to developing a more equitable system that provides access to health insurance to millions more Americans. The Health Policy Consensus Group, composed of experts from many market-based think tanks and academic institutions, has developed a vision statement outlining our approach to solving this problem.³⁰

They believe that:

Every American should be able to obtain needed medical care. Reforming the tax treatment of health insurance is central to achieving this goal.

Congress could begin by providing a new set of incentives for people who do not have health insurance. These incentives should be properly structured to

create an opportunity for everyone to purchase his or her own health coverage in an open and competitive market.

We recommend providing credits or other comparable fixed incentives, explicitly determined by legislation, to assist people in obtaining private health insurance.

Millions of Americans not eligible for the current tax subsidy would receive help in purchasing health insurance, and this assistance can be targeted to those who most need help in purchasing insurance in a reformed marketplace.

OPTIONS AND INITIATIVES FOR CHANGE

It is essential that the United States lead the way into a new era to finance health coverage, not only to solve its own problems and bring millions of people into the system but also to demonstrate how the U.S. can create a health care system that can respond to the pressures and demands of the 21st century, including moderating costs and increasing access to health insurance while maintaining a climate that supports innovation.

The United States is recognized around the world for the quality of the medical care it offers, including development of and widespread access to the latest technologies. One of the major reasons for the continued progress in medicine here is the system of rewards and incentives for innovation, including competitive pricing and strong patent-protection laws.

The competitive marketplace dictates that health care providers and health insurers continue to keep pace with medical innovation in order to stay in business. For example, private health insurance companies must provide access to new technologies to keep their customers. But they also must attend to their bottom line, lest they lose business to lower-cost competitors. When a new surgical technique, such as arthroscopic surgery, is introduced, it is quickly adopted. While the equipment and the surgery may be more expensive, it almost always can be done in an outpatient surgical center, making the surgical procedure much easier on the patient and often saving hospitalization costs – a win/win scenario for payers and patients.

Market incentives fuel innovation and change in the private health sector and also have contributed to significant private investments in the development of new

pharmaceuticals -- \$59 billion in 2007.³¹ Ninety-eight percent of all private health plans provide some coverage for prescription drugs because the plans see the value in providing access to needed medicines.³² If a patient can be spared a \$28,000 surgery for ulcers by taking a \$500 medicine, why wouldn't the health plan want to pay for that? Virtually all do. But if market pricing and incentives for development of new products were eliminated or even compromised, it is unclear who would pay for development of tomorrow's medical miracles.

A market-based policy prescription

Congress and the new administration could dramatically expand access to private health insurance through three key policy moves:

1. Providing new subsidies to individuals to purchase private health insurance and creating a pathway to universal coverage
2. Creating new markets for affordable, portable insurance
3. Protecting those with pre-existing conditions so they can purchase and maintain insurance coverage.

1. New individual subsidies: Instead of the subsidies currently provided to support job-based health insurance, all Americans not eligible for Medicare, including the currently uninsured, would receive direct subsidies to help them purchase private insurance. The subsidies could be in the form of direct vouchers or tax credits that would be refundable so people would be eligible for the full value even if they don't owe taxes.

The credit would give families much more control over their health benefits and would allow health insurance to be portable so people don't have to lose their insurance if they lose or change jobs.

The credits could be used only to purchase insurance, but people would have a range of options from which to choose. The great majority of Americans likely would continue to choose to receive their health insurance at work; replacing the current tax invisible tax break for employees with job-based insurance with the new direct tax credit to individuals would be little more than a bookkeeping change.

As a transition, policymakers could begin with a system of refundable tax credits for the uninsured to purchase insurance, supporting private insurance that would be portable and that would give them the option of selecting policies that fit their needs and pocketbooks.

Achieving universal coverage: If the credit were universally available, it could be a mechanism to provide health coverage to everyone, without moving further toward a government-dominated health system. People would have the option of selecting a plan that suits them and their families, using the credit to defray premiums. Some may choose to supplement the credit and buy more generous coverage. But even those who don't take action to buy a policy could have one assigned to them, thereby obtaining insurance by default through one of the health plans offering private policies in their region.

In addition, wise policymakers would provide supplementary payments to help those with low incomes and high health risks to help pay their premiums.

2. Interstate purchase of health insurance: We recommend a system in which people would be able to purchase health insurance in a national market that is more competitive and offers more options for coverage. Opening the health insurance market to nationwide competition would give people many more choices of policies that aren't burdened by state mandates and regulations that drive out competition and drive up prices in the current system.

Economists Steve Parente, Roger Feldman, Jean Abraham *et al* showed in a University of Minnesota study that opening up competition among the states for health insurance would mean at least an additional 12 million people could get health insurance, without any new spending by the federal government.³³

People could choose the best plan for them and their families and, by their choices, would put pressure on companies to wring out excessive overhead costs and offer innovative plan options.³⁴

In a reformed marketplace, people would seek other groups, such as professional and trade associations and churches, through which they could purchase health insurance to receive group discounts. This would lead to better continuity of coverage and care and greater control over choosing health insurance benefits and providers.

Portability of the subsidies for health insurance leads to greater security in health coverage since people would have control over their policies. Further, patients

wouldn't be forced to change from one doctor or one network to another when their employer changes insurers or when they change jobs.

A competitive marketplace would force insurers to provide adequate benefits to attract and keep customers. In a larger national market, individual consumers, rather than government bureaucrats or legislators, would decide what benefits and policy structures they want.

States that wish to expand options for their citizens could join with other states to enlarge their pools and lower overhead costs.

Guaranteed Access Plan: While more than 10 million people buy health insurance in the individual market today, many others find it difficult if not impossible to find an affordable policy. Critics have raised concerns that giving people more freedom to purchase health insurance outside the workplace would mean these higher-risk individuals would be denied coverage, especially if they have pre-existing conditions or otherwise have trouble getting insurance.

State-based Guaranteed Access Plans, governed by boards of citizens, legislators, business, and medical community leaders, could provide the solution. The plans would cover patients who have been denied insurance through a system of shared risk among the insurers participating in a particular market. Idaho has had a functional guaranteed access pool since 2000 that is funded by reinsurance premiums paid by carriers ceding risks to the pool, by a portion of the state's premium tax revenue, and carrier assessments, when needed.³⁵

The federal government could establish new payments to the states to support their high-risk pools and provide guidance in setting up these pools so they are able to provide a safety net for people who still are unable to purchase or afford coverage. These policy proposals build on the current system and fill the gaps with new incentives, subsidies that are better targeted, and new programs to assist those who are being left behind in the current system.

Health plans also could be given new incentives to reduce costs through programs such as disease management, individual case management, and health and wellness programs. Disease management programs reach out to people who are at risk for certain diseases and chronic conditions and provide them with care managers and specialized support to make sure they receive the proper care.

Challenges for 2009 and beyond

Health reform will be at the center of the 2009 policy debate U.S. The question for policymakers is whether reforms to our health sector will be controlled by government or by consumers in a free and competitive marketplace. The debate now is moving toward greater centralization, but the experiences of European health system with significant government involvement indicate that will not solve the problems of cost, quality, and access.

The challenge is to create a climate that will provide incentives to promote good health and to embrace the changes that will lead to a wiser use of technologies. By relying on market forces, the expensive and demoralizing burden of excessive regulation and paperwork can be lifted. Innovation and competition, rather than bureaucracy, can drive change, so the children of the 21st century will be the beneficiaries of medical miracles we can only imagine today.

Grace-Marie Turner is president of the Galen Institute, a non-profit research organization focusing on free-market ideas for health reform based in Alexandria, VA. She can be reached at gracemarie@galen.org. Research Director Tara Persico assisted in producing this paper.

ENDNOTES

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Galen Institute
P.O. Box 320010
Alexandria, VA 22320
703-299-9000
www.galen.org