

# US Healthcare System Overview-Background

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## Basic Information

The United States (US) has a population of over 330 million people<sup>1</sup> and is supported by one of the most complex healthcare systems in the world, formed by intertwining relationships between providers, payers, and patients receiving care. The US healthcare system is in a constant state of evolution.

### Description of the Healthcare System

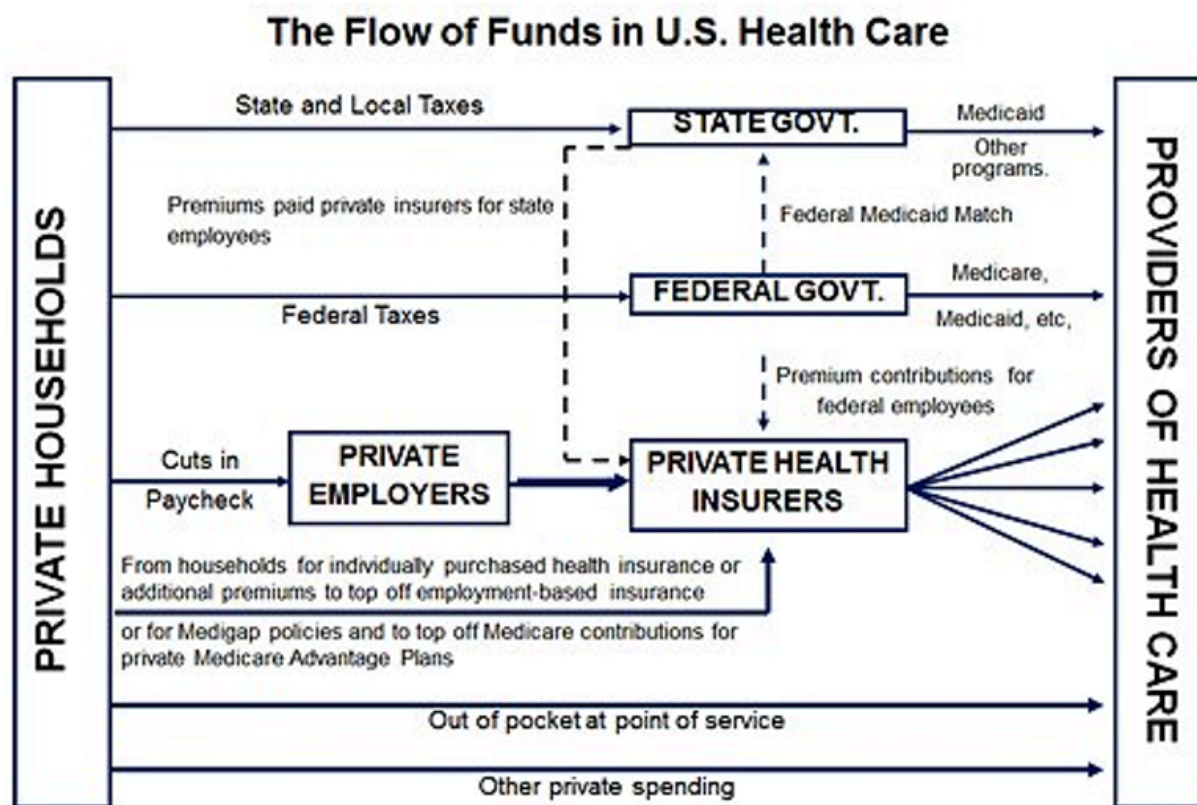
#### Coverage Overview

The US healthcare system does not provide universal coverage and can be defined as a mixed system, where publicly financed government Medicare and Medicaid (discussed here (<https://www.ispor.org/heor-resources/more-heor-resources/us-healthcare-system-overview/us-healthcare-system-overview-decision-makers-and-influencers-page-1/#medicare-medicaid-link>)) health coverage coexists with privately financed (private health insurance plans) market coverage. Out-of-pocket payments and market provision of coverage predominate as a means of financing and providing healthcare.<sup>2</sup> As of 2019, around 50% of citizens received private insurance coverage through their employer (group insurance), 6% received private insurance through health insurance marketplaces (nongroup insurance) (discussed here (<https://www.ispor.org/heor-resources/more-heor-resources/us-healthcare-system-overview/us-healthcare-system-overview-background-page-2/>)), 20% of citizens relied on Medicaid, 14% on Medicare, and 1% on other public forms of insurance (eg, Veterans Health Administration [VHA] and Military Health Service [MHS]), leaving 9% of Americans uninsured.<sup>3</sup>

#### Healthcare Financing

Note that this section is intended to give an overview of how healthcare financing works in the United States. For a more in-depth description of the stakeholders, utilize the hyperlinks to learn more. An overview of the financial flow of the US healthcare system is presented in Figure 1.

Figure 1. Financial Flow of the US Healthcare System



Source: Reinhardt UE. *The Money Flow From Household to Health Care Providers* (2011)<sup>4</sup>

## Hospital and Physician Financing

Public and private hospitals receive payment from both public and private financing sources. Hospitals are typically paid through a diagnostic-related group (DRG), which assigns a set payment amount for a particular condition or treatment sequence. Inpatient DRGs are widely used by the Centers for Medicare & Medicaid Services (CMS) and by many private payers as a payment scheme for hospitals. Rather than paying the hospital for a line-item list of procedures and medications, Medicare pays the hospital a fixed amount based on the DRG, regardless of the actual cost of treatment. The DRG-based payments cover accommodation costs in a hospital (ie, room and board, facility costs, etc), procedure costs, support staff (nurses, technicians, etc), and drug/medical device costs; however, this system does not include physician fees. In the outpatient setting, Ambulatory Payment Classification (APC) codes are used by the hospital system for billing and reimbursement. These APC codes represent a fee-for-service style of billing, rather than the capitated, cost-based style of DRGs.<sup>5</sup>

Physician fees are not included within DRG (inpatient) or APC (outpatient) codes. When billing for physicians and other clinician fees, Current Procedural Terminology (CPT) codes are used and are billed under the name of the provider rather than the hospital. CPT codes may be used in both the inpatient and outpatient settings and are indicative of a fee-for-service healthcare reimbursement structure.

Private insurers pay hospitals based on DRGs, case rates, per diems, fee-for-service, and/or discounted fee-for-service schemes. On average, these payments exceed the hospital's costs of providing the underlying services. Conversely, hospitals, on average, are reimbursed less than the costs of services for Medicare, Medicaid, and uninsured patients.

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