US Healthcare

The United States has a population of over 330 million people[1] 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 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. 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) , 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.

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.

Insurance Plans

Private Insurance Plans

There are numerous national private health insurance plans, as well as regional and self-insured plans (organized by large companies). In the United States, it is common for employers to contribute to private insurance premiums, usually as monthly premiums to maintain health coverage, either in whole or part for their employees (group insurance).

Public Insurance Programs

Public health insurance programs (eg, Medicare, Medicaid, and the Children's Health Insurance Program [(CHIP]) are operated by CMS and are financed primarily by government taxes. Medicare is the largest single payer in the United States, providing healthcare coverage for those ages 65 years and older, regardless of income or medical history, and those under the age of 65 with permanent disabilities or end-stage renal disease. Medicaid provides care to individuals below the poverty level and to those who cannot afford to pay for healthcare given their eligibility and is jointly funded by both the federal government and individual states. Each state sets its own guidelines regarding eligibility, services, and reimbursement.

Individual Financing

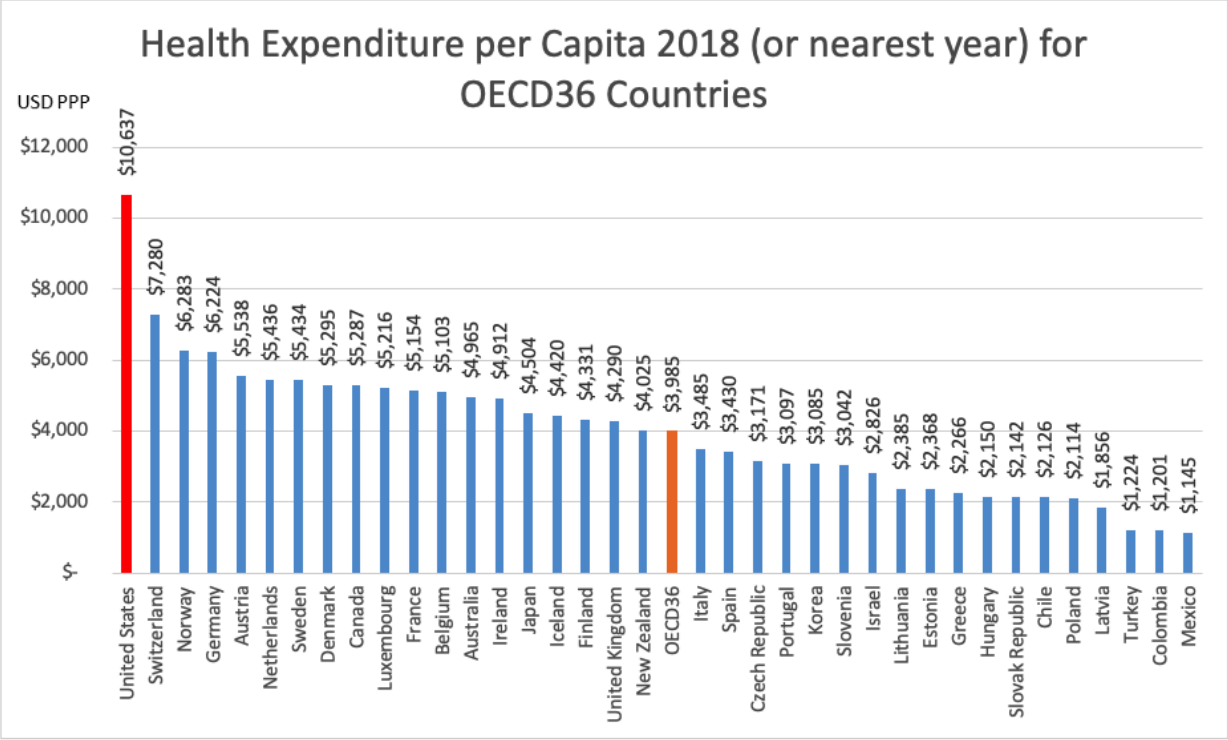
At the individual level, healthcare financing by patients with health insurance often includes copayments (fixed cost for a medical service or product) or coinsurance (a proportion of the total cost of the medical service or product). In addition to copayments or coinsurance, patients often have a deductible—a specified amount of money that the insured must pay before an insurance plan will pay for healthcare—and premiums. These patient costs are considered “out-of-pocket” spending. Patients without health insurance are forced to pay the complete cost for care, including what insurance companies would normally pay, out of pocket.

Regulation and Policymaking

Federal healthcare laws are enacted and amended through Congress, the legislative branch of government. Policy can also be changed through the regulatory process, whereby the federal branch of the government interprets how policies are to be implemented and enforced. In the United States, the Department of Health and Human Services (HHS) is responsible for the provision of medicine, public health services, and social services at the national level. The HHS is part of the federal branch of government and is the oversight agency for healthcare organizations in the country such as the Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS), National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and Centers for Disease Control and Prevention (CDC).

Health Statistics Information

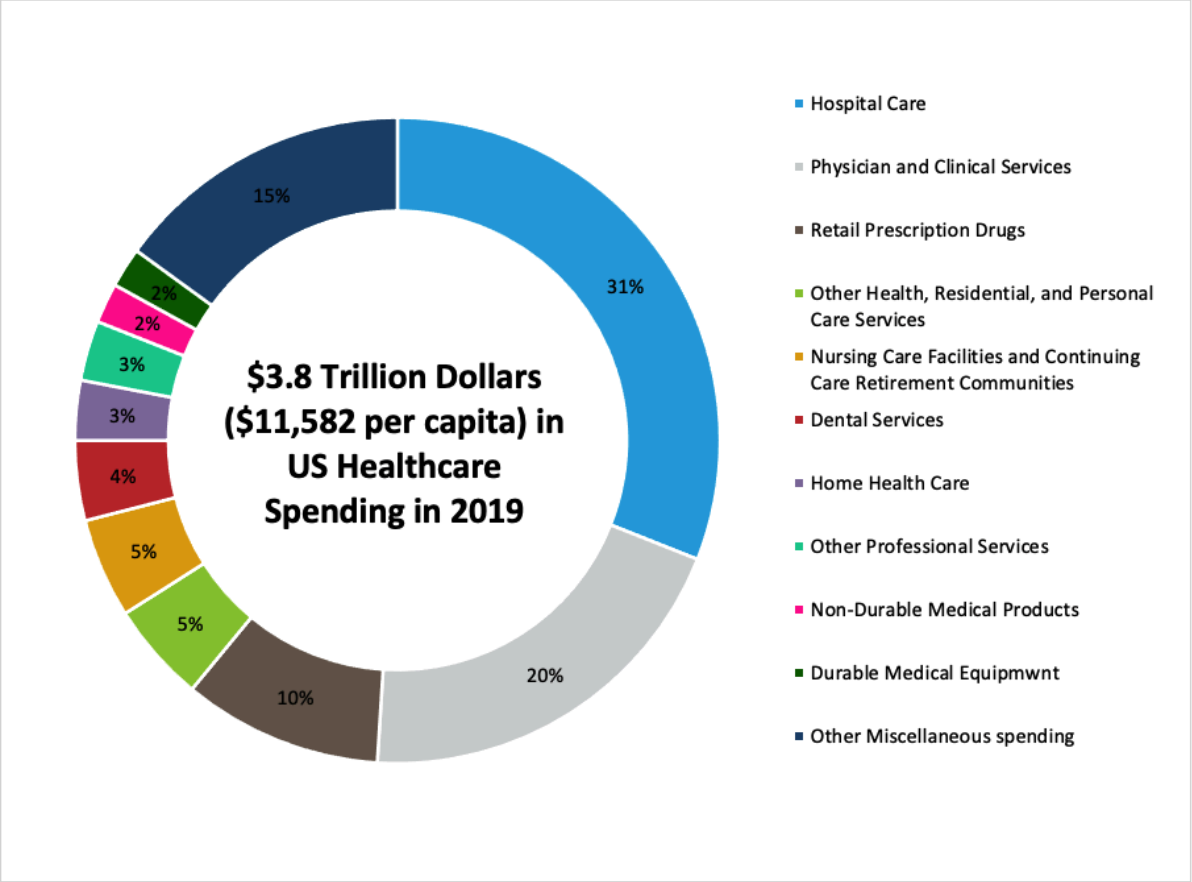
The United States is the third most populous country in the world, behind China and India, but has a population that is only about one-quarter of either of those 2 countries. Nevertheless, it spent $3.5 trillion on healthcare, or 16.9% of the gross domestic product (GDP), (more than any other country) in 2018.[19,20] Comparable healthcare spending estimates include Switzerland (12.2%), the second-highest country, as well as Germany (11.2%) and the United Kingdom (UK) (9.8%). Figure below, illustrates the per capita spend of the United States on healthcare relative to other developed nations.



Source: OECD Health Statistics 2018, WHO Global Health Expenditure Database.[20]

In the United States, hospital care is the main driver of overall healthcare spending, accounting for 33% of 2017 healthcare dollars, physician and clinical services are second at 20%, and prescription drugs are third at 10%. See Figure 4 below for a more complete breakdown of total healthcare spending in the United States.

Figure below, 2017 Healthcare Spending by Type of Service or Product in the United States



Source: National Health Expenditures 2019 Highlights. [6]

Major Healthcare Stakeholders

Regulators and Policymakers

The US Department of Health and Human Services (HSS is responsible for protecting health and providing essential human services for all Americans. Several agencies function under HHS. HHS and state-level departments of health are responsible for developing and supervising the implementation of health policies, as well as managing a large part of healthcare expenditure via CMS. However, there is no strict target for federal- or state-wide healthcare expenditure.

Agency for Healthcare Research and Quality : The AHRQ's mission is to produce evidence to make healthcare safer, of higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used.

Centers for Disease Control and Prevention : The CDC, part of the Public Health Service, protects the public health of the nation by providing leadership and direction for the prevention and control of diseases and other preventable conditions and responding to public health emergencies.

National Institutes of Health : The NIH, part of the Public Health Service, supports biomedical and behavioral research within the United States and abroad, conducts research in its own laboratories and clinics, trains promising young researchers, and promotes collecting and sharing medical knowledge.

Office of Inspector General : OIG protects the integrity of HHS programs as well as the health and welfare of the program participants.

The US Food and Drug Administration : The FDA, part of the Public Health Service, ensures that food is safe, pure, and wholesome; human and animal drugs, biological products, and medical devices are safe and effective; and electronic products that emit radiation are safe. In addition, FDA oversees regulatory approval of drugs, biologics, diagnostics, and devices in the United States.

Payers

Centers for Medicare & Medicaid Services : CMS represents the public health insurance provider for around 30% of Americans and combines the oversight of the Medicare program, the federal portion of the Medicaid program and CHIP, the Health Insurance Marketplace, and related quality assurance activities.

Medicare: Medicare is a single-payer national health insurance program that began in 1966. Funding for this program comes from payroll taxes, premiums and surtaxes from beneficiaries, and general federal revenue. It primarily provides health insurance to Americans aged 65 and older who have paid into the Social Security system through payroll taxes. Additional health insurance coverage through Medicare is provided to younger people with some disability, patients with amyotrophic lateral sclerosis, or patients with renal failure requiring dialysis or transplant. Coverage for Medicare is broken down into 4 parts, A through D. Traditional Medicare plans (A, B, and D) do not contain an out-of-pocket spending limit.

Part A: Medicare Part A coverage relates to inpatient hospital costs, skilled nursing, and hospice services.

Part B: Medicare Part B coverage relates to outpatient physician services. Durable medical equipment (DME), such as diabetic testing supplies, is covered under these plans. Some drugs also may be covered under Medicare Part B and are usually treatments that require the intervention of a physician to administer, such as chemotherapy, immunosuppressant drugs, and dialysis drugs.

Part C: Also known as a Medicare Advantage (MA) Plan, Medicare Supplement Plans, or Medigap, Part C coverage is an alternative to traditional Medicare that allows patients to choose private plans with at least the same benefits of Parts A and B, and often D (as a Medicare Advantage Prescription Drug [MAPD] plan). These plans provide an annual out-of-pocket spending limit, which traditional Parts A and B plans do not contain.

Part D: Medicare Part D coverage relates to prescription drug coverage. This coverage has a standard benefit design for all patients. See Figure 5 below for a breakdown of costs for Medicare Part D plans in 2019.