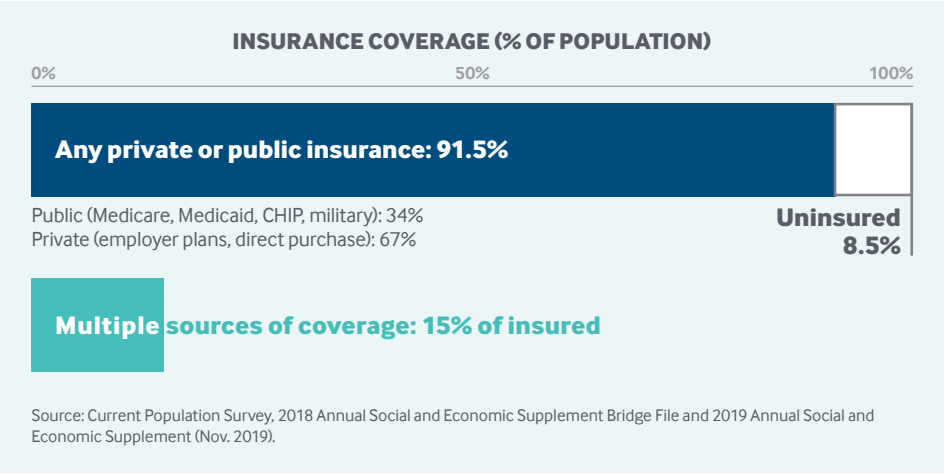
HEALTH SYSTEM OVERVIEW

United States

The U.S. health system is a mix of public and private, for-profit and nonprofit insurers and health care providers. The federal government provides funding for the national Medicare program for adults 65 and older and some people with disabilities, as well as for various programs for veterans and low-income people, including Medicaid and the Children's Health Insurance Program. States manage and pay for aspects of local coverage and the safety net. Private insurance, the dominant form of coverage, is usually provided by employers. The uninsured rate of 8.5 percent is down from 16 percent in 2010, when the landmark Affordable Care Act (ACA) was enacted. Insurers set their own benefit baskets and cost-sharing structures, within federal and state regulations.



Source: Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement (Nov. 2019).

HEALTH CARE DELIVERY AND PAYMENT

Primary care practitioners work mostly in private practice. Primary care physicians are paid through a combination of methods, including negotiated fees (private insurance), capitation (private insurance and some public insurance), and administratively set fees (public insurance). The majority (66%) of primary care practice revenues come from fee-for-service payments. Practitioners generally have no gatekeeping function; patients have free choice of physician. *Patient cost-sharing:* Most patients face cost-sharing, varying by insurance type. Some plans cover primary care visits before the deductible is met and require only a copayment.

Specialists work in outpatient private practice or hospitals; some work in both. Single-specialty practices predominate. Specialist practices are increasingly integrating with hospital systems and consolidating with each other. Outpatient specialists can choose which form of insurance they will accept; for example, not all specialists accept publicly insured patients, because of the relatively lower reimbursement rates set by Medicaid and Medicare. Access to specialists for beneficiaries of these programs can therefore be particularly limited. *Patient cost-sharing:* Varies by type of insurance. Most private insurance includes deductibles, with lower cost-sharing for use of in-network providers.

Hospitals are mostly nonprofit (56%), with the remainder public or for-profit. Main forms of payment are: prospective diagnosis-related group (DRG) rates for Medicare; DRG, per-diem, or cost reimbursement for Medicaid; and negotiated per-diem fees for private insurance. *Cost-sharing:* Medicare charges full cost up to $1,364 deductible for days 0–60; thereafter, $0 per day. Cost-sharing applies for stays over 60 days. Copayment required by most private plans. Medicaid charges $75 maximum per stay for most patients.

DEMOGRAPHICS

325.7M
Total population

16.0%
Population age 65+

HEALTH SYSTEM CAPACITY & UTILIZATION

2.6
Practicing physicians per 1,000 population

4.0
Average physician visits per person

11.7
Nurses per 1,000 population

2.8
Hospital beds per 1,000 population

125
Hospital discharges per 1,000 population

December 2020

The Commonwealth Fund

United States

Prescription drug benefits are covered by most plans and are mandated for ACA marketplace plans. Each insurer has its own formulary. Medicare beneficiaries can purchase private, voluntary "Part D" prescription drug plans. Private and Part D plan pharmacy benefit managers, state Medicaid programs, and the VA separately negotiate drug discounts with manufacturers. *Cost-sharing:* Varies by insurer; deductible typically applies. Private insurers often have lower cost-sharing for generic or preferred brand-name drugs.

Mental health benefits are determined by each insurer. The ACA mandates that marketplace insurers cover mental health and requires private insurers to provide same level of benefits for mental and physical health conditions. Many employer-sponsored plans provide benefits through managed behavioral health care organizations. Providers are mostly private, but federal, state, and local governments fund some services. Medicaid is the single largest funding source of mental health services. *Cost-sharing:* Varies by insurance type; lowest in Medicaid.

Long-term care is not universally covered. Public spending represents 70 percent of total spending on long-term care services, with Medicaid accounting for the majority of that spending. Medicare and most employer-sponsored plans cover only postacute skilled short-term nursing services, short-term nursing home stays following hospitalization, and hospice care. Private long-term care insurance is rarely purchased. Unpaid caregivers provide most care. *Cost-sharing:* Considerable. Individuals must spend down assets to qualify for Medicaid.

Safety nets include public hospitals and federally qualified health centers providing low-cost care to poor and uninsured; Medicaid and CHIP coverage; premium subsidies for low- and middle-income families in ACA marketplace plans; federal and state funding for hospitals caring for uninsured patients; Medicare prescription drug plan subsidies; and out-of-pocket caps in some private plans. Some cost-sharing exemptions or reductions vary by insurance type, including for low- or middle-income families under marketplace plans; low-income children under Medicaid; American Indian/Alaskan Native children under CHIP; and preventive services for Medicare and marketplace insurance.

Care coordination is incentivized through a number of ACA provisions designed to promote patient-centered medical homes, episode-based bundled payment programs, and accountable care organizations. The law expanded the Centers for Medicare and Medicaid Services' ability to test alternative payment models that reward quality, aim to better coordinate care, and reduce costs.

TOTAL HEALTH EXPENDITURES

Annual per capita health expenditures are the highest in the world — USD 11,172, on average, in 2018. In 2017, public spending accounted for 45 percent of total health care spending, or approximately 8 percent of GDP.

RECENT REFORMS

- Two bills passed in 2018 banned so-called gag clauses in contracts between pharmacies and pharmacy benefit managers that have prevented pharmacists from informing customers when the cash price (without insurance) for a drug is lower than the negotiated price. In addition, new federal rules require all hospitals to post their charges for medical procedures online and update the list at least once a year.
- The Primary Care First model, announced in 2019 and targeted for launch in 2021, is a new voluntary payment model intended to simplify primary care physician payments under Medicare.
- New regulations allow states to offer lower-cost, minimally regulated insurance options that do not meet the ACA's minimum consumer protections.
- Several states have introduced work requirements for Medicaid beneficiaries.

SPENDING

$10,586
Health care spending per capita

$1,122
Out-of-pocket health spending per capita

$1,220
Spending on pharmaceuticals (prescription and OTC) per capita

HEALTH STATUS & DISEASE BURDEN

78.6
Life expectancy at birth (years)

40.0%
Obesity prevalence

10.8%
Diabetes prevalence

28%
Adults with multiple chronic conditions (2 or more)

Data: 2019 OECD Health Data except: diabetes prevalence from *Health at a Glance 2019* (IDF Atlas 2017 data); adults with 2+ chronic conditions from the 2016 CMWF International Survey.