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FORMS OF HEALTH CARE DELIVERY IN THE UNITED STATES OF AMERICA

In the United States of America (USA), health care can be predominantly obtained through private health insurance (individually purchased or employer-provided), under publicly funded social security programs (among which most common are Medicare and Medicaid schemes), and since 2010, through mandatory health insurance. On the USA territory, the most up-to-date healthcare technology is used, total spending on health care is extremely high (as a consequence of increased demand for health care services, higher investments in scientific researches in the area of healthcare, etc.), whereas in 2000, the World Health Organization ranked the U.S. health care system only 37th. Life expectancy in the USA does not rank among the top in the world, and for particular categories of insureds there is no adequate access to health care. The changes introduced to the U.S. health care system are aimed at resolving the aforementioned problems. The implementation of mandatory health insurance seeks to create conditions for the provision of universal health coverage and a strong correlation between high health care prices and high health care efficiency.

Key words: *health insurance, health care, USA, Medicare scheme, Medicaid scheme.*

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Introduction

Diseases and injuries represent major living and social risks for the population. To manage these risks, countries use different approaches to health care systems (mainly as fundamental right provided by the participation in the health insurance system). The U.S. population health improvement strategy contains a large number of provisions relating to the health insurance and health care. In the USA, private health insurance and the delivery of health care services in private health sector are predominant. Social security program, OASDHI for short (Old age, Survivors, Disability, Health insurance), includes the „insurance programs for the elderly, surviving dependents, the disabled and the sick". This social security program is developed with the aim to resolve complex social issues which are hard to tackle for the individuals alone (this program is defined in the Social Security Act of 1935). In 1965, a so-called Medicare program was enacted for the provision of medical care to, mostly, elderly people, whereas a so-called Medicaid program caters for the needs of the poor. The Patient Protection and Affordable Care Act-PPACA, or commonly called Affordable Care Act-ACA, was adopted in March 2010. This Law stipulates that all taxpayers are covered by health insurance. The objective of this paper is to analyze the operation of health insurance and health care delivery system in the USA and highlight key features and specific characteristics of the most common forms of health care. In almost all European countries, publicly-funded (mandatory) health insurance is prevalent, whereas in the USA, as previously mentioned, private health insurance is predominant. While the majority of European countries seek to achieve higher penetration of private pension insurance, a couple of years ago, the USA started implementing mandatory health coverage. The USA experience regarding health care delivery is important, among others, for those countries that plan to embark on the same or similar reform processes in the area of health insurance and health care.

1. USA Development and Main Characteristics of Health Insurance System

The USA is a federal constitutional republic composed of 50 states and one federal district. In 2015, the U.S. population was about 321 million (39 million people in California, approximately 27 million in Texas, 20 million in Florida, etc.).[2] The U.S. economy is highly developed. Its Gross Domestic Product (GDP) in 2014 amounted to 17.420 billion $, which accounted for one-third of the total world GDP.[3] In May 2014, approximately 135 million

2 http://www.census.gov, information downloaded on 22-04-2016

3 http://data.worldbank.org/ country/united-states, information downloaded on 22-04-2016.

citizens were employed in the USA with average wages of 47.230$, and in the same month, in 2015, employed were about 138 million citizens earning on average 48.320$.[4] In December 2014, the unemployment rate was 5.6%[5], and in December 2015, it amounted to 5.0%.[6] The USA has a specific health insurance model which covers the majority of employed population and their families, and is employer-sponsored (provided) through the private insurance companies. There are three types of private health insurance: hospital (or insurance of hospital expenses), medical and surgical.[7] In addition to private health insurance, since the mid-1970s, Medicare and Medicaid programs have been defined for the health care of elderly and low-income population. In 2010, after the adoption of the Affordable Care Act-ACA, foundations were laid for mandatory health insurance. In 2013, in the USA, 13.3% of the total population were not covered by health insurance (41.8 million people), and in 2014, this percent amounted to10.4% (33 million).[8] Some ¾ of the uninsured persons accounted for the population younger than 35.[9] It is estimated that after the change in health insurance funding additional 32 million people will be covered, meaning that the goal of new legal solutions is to create conditions for the implementation of universal health coverage. According to the particular provisions of the aforementioned Law, private insurance companies will also be required to provide coverage to „high-risk" population (those who already have health problems); children, until they turn 26, will be health insurance beneficiaries through their parents, policyholders; whereas small businesses, which provide health insurance to their employees, will have tax reliefs, etc.

In 2014, 89.6% of the population were insured.[10] Out of the total number of people covered by health insurance, some 66% were insured within private health insurance (approximately 55% had employer-based health insurance and 11% had directly purchased private insurance).[11] Group health insurance is most represented. There are two reasons behind this high representation of

4 United States Department of Labor, Bureau of Labor of Statistics, May 2014, May 2015, http://www.bls.gov/oes/2014/may/oes_nat.htm#31-0000, information downloaded on 24-04-2016.

5 Information downloaded from http://www.bls.gov on 24-04-2016.

6 In the last ten years, the highest unemployment rate was in 2009 and amounted to 9.9%, largely as a consquence of the Global Financial Crisis.

7 Rakonjac-Antić T.; Penzijsko i zdravstveno osiguranje, Publishing Centre, Faculty of Economics, University of Belgrade, 2012, pp. 241.

8 Smith J., Medalia C.; Health insurance coverage in the United States: 2014, U.S. Census Bureau, 2015, pp 3.

9 Rakonjac-Antić T.; Penzijsko i zdravstveno osiguranje, Publishing Centre, Faculty of Economics, University of Belgrade, 2012, pp. 241.

10 About 19% population participated in multiple forms of health care provision.

11 Smith J., Medalia C.; Health insurance coverage in the United States: 2014, U.S. Census Bureau, 2015, pp 5.

group health insurance: rationalization of costs (one contract covers more than one person) and tax reliefs.[12]

Total spending on health care in the USA has been high for good many years (see the Table no. 1). Key reasons lie in the growth in life expectancy resulting in the increased use of health care services, emergence of new diseases, investments in science and technology, etc.[13] In 2014, the USA saw the highest total health care expenditures which amounted to 17.1% of GDP, compared to other countries in the world (for example, in the same year, this percent was 11.2% in Austria, 9.4% in Australia, 10.6% in Belgium, 10.4% in Canada, 11.5% in France, 9.2% in Italy, 11.3% in Germany, 9.7% in Norway, 11.7% in Switzerland, 9.1% in Great Britain, etc.).

Table no. 1. Total spending on health care in the USA as a GDP percent, by selected years

Year	1929	1965	2000	2002	2005	2008	2009	2010	2011	2012	2013	2014
% of GDP	3.5	5.7	13.1	14.7	15.6	16.0	17.0	17.0	17.1	17.0	16.9	17.1

Source: www.who.com, www.cms.gov

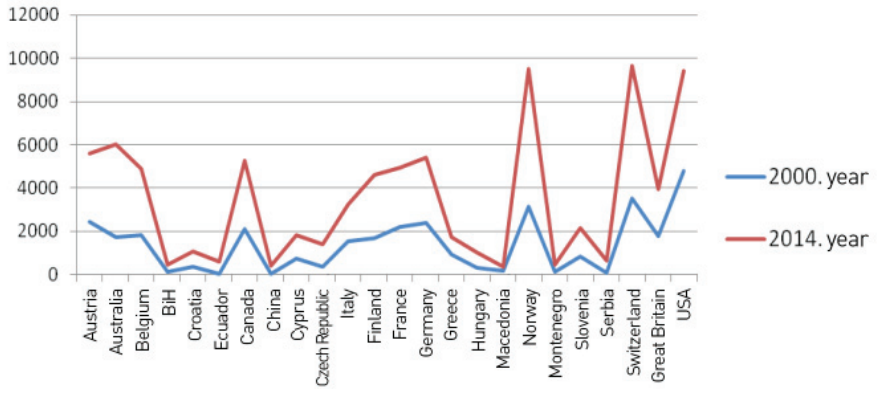
From 2010/2011 to 2014 the total health care spending was slightly changed and amounted to about 17% of GDP (Table no. 1). One of the main reasons for curbing this significant rise in health care expenditures in this period is the increased share of insureds and employer-sponsored health care plans in the health care costs. Increased were so-called „deductibles" i.e. the amount that participants are first required to spend on health care to be able to subsequently receive health care benefits from an insurance company. In 2013, this amount of deductible increased to 1.135$, from 584$ in 2006.[] The rise in drug use was also slowed down, mostly due to a larger use of generic drugs, particular changes in payments to insurance companies under the government program for the provision of health care to the elderly, etc.[14] In 2000, in the USA, the costs of health care per capita amounted to 4.788$, whereas in 2014, they rose to 9.403$ per capita. It is interesting to note that in the same period, the health care expenditures in Norway and Switzerland increased by about three times (see the information shown in the Chart no. 1.)

12 Stiglitz J.E.; Economics of the Public Sector, Publishing Centre, Faculty of Economics, University of Belgrade, 2004.

13 Erixon F., Marel E.; What is driving the rise in health care expenditures?, ECIPE working paper No 05/2011, Belgium, pp. no. 11.

14 Ibid, pp. 147-178.

Chart no. 1 Health insurance expenditures per capita, in $, by selected countries, in 2000 and 2014



Source: World Health Organization Global Health Expenditures database (http://apps.who.int/nha/database)

According to the ranking of the world's health systems carried out in 2000 by the World Health Organization, France ranked 1st, Italy 2nd, Austria 9th, Norway 11th, Germany 25th, Canada 30th, Costa Rica 36th, the USA 37th, Slovenia 38th etc. The results of this report produced different reactions. The low ranking of U.S. health care system attracted the closest attention in professional circles. At that time, the share of total health insurance costs was 13.1% of GDP (see the Table no. 1) and, as aforementioned, 4.788 $ per capita were allocated for health care while in the health care system an up-to-date medical and information technology was used (and is still used). According to the data for 2013, life expectancy was 79 years of age (for women 81, and for men 76), which was lower than the life expectancy in Canada (82), Norway (82), Italy (83), Switzerland (83), Japan (84) etc.[15] It will be interesting to note the following data: in the period 2007-2013 there were 24.5 doctors per population of 10000 (e.g. in Switzerland 40.5, Norway 42.8, Germany 38.9 etc.), 8.8 pharmacists, and in 2014, 1.2 psychiatrists.[16] In this period, more than one hundred million U.S. citizens were insured under public health care programs.

2. Public Health Care Programs

The most represented public health care programs are: Medicare (provision of health care to elderly), Medicaid (provision of health care to low

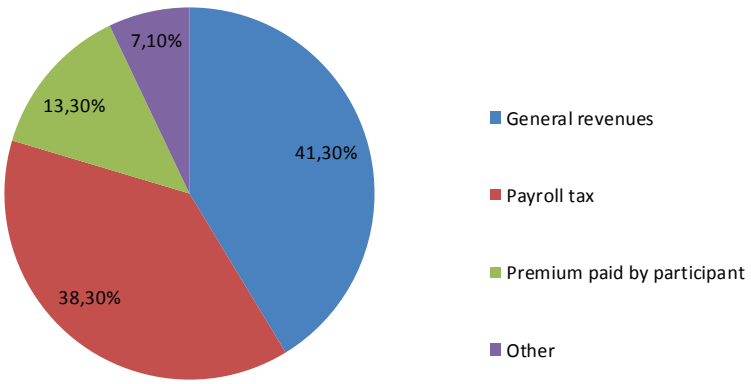
15 Ibid, pp. 50.
16 World Health Statistics 2015, Part II, Global Health Indicators, pp. 114-123.

income population), Children's Health Insurance Program - CHIP, Military Health System, etc. As already mentioned, since mid-1970s, Medicare and Medicaid programs have been operating on the U.S. territory. Medicare program provides health insurance coverage to persons:

a) 65 years of age and older;
b) who receive disability benefits from Social Security;
c) who are diagnosed with End Stage Renal Disease.

In 2013, the program covered about 52.3 million persons, out of which 43.5 million aged 65 and older, and 8.8 million of persons with disabilities.[17] Medicare health insurance program is a part of government health insurance and is financed mostly from the government budget. In 2013, the total of about 575.8 billion $ were invested in Medicare. Some 80% of revenues were comprised of general revenues and payroll taxes (see Chart no. 2).

Chart no. 2 Structure of Medicare revenue sources in 2013[18]



Source: The 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, pp. 11.

Medical services may be provided in physician offices, hospitals etc. which have entered into contracts with the „programs". A traditional Medicare program is basically comprised of two parts (Part A and Part B),

17 The 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, pp. 7.

18 General revenues amounted to 237.7 billion $, payroll taxes 220.8 billion $, premiums paid by participants 76.4 billion $ and other revenues 40.9 billion $.

and is subsequently extended to include new Part C and Part D. The first part includes Hospital Insurance and is also called Part A[19]. For this type of insurance no additional premium payments are required because it is considered that the insureds had paid sufficient funds for health insurance while they were employed. This Part includes the following: hospital care, nursing home care and outpatient care. The second Part is optional (additional) health insurance (also called Part B or Medical Insurance) and includes particular costs which are not covered in the first Part such as: outpatient hospital care, physical therapy, etc. This form of insurance requires additional premium payment by the insured and additional payment of contributions for each insured by the Federal Government. In 1997, Part C was introduced, also called Medicare+Choice Selected Program or Medicare Advantage plans – „MA plans", which includes medical services not included in Part A and Part B , such as, for example, dental care, vision care, etc. The insureds are required to be the members of Medicare Part A and Part B to be able to participate in Part C. There is also a Part D under which Prescription Drug Coverage is provided. In 2015, out of the total number of Medicare beneficiaries, 69% of persons participated in the traditional Medicare program. There is also a Medigap program which represents supplementary insurance and includes the services not provided under the traditional Medicare program. To be eligible for using Medigap program services, beneficiaries must participate in the traditional Medicare program. According to the demographic projections, in the next years, Medicare program will become extremely popular. It is envisaged that in 2040, population aged over 65 will account for about 20% of the total population.

Medicaid program (health care provided to persons with low income) provides health coverage for the unemployed and poor persons. This health care program has the character of a public aid and is funded from the Budget, which means that the funds for this type of health insurance are paid by all taxpayers.[20] Persons eligible for Medicare program may also be insured under Medicaid program if they need social security.[21] In such situation, these persons receive higher amounts of health benefits. Medicaid program provides health care for about 62 million people. Generally, Medicaid comprises four public health insurance programs. The first program ensures compensation of health care costs for children and women. The second program ensures the compensation of medical costs not included in Medicare. The third program covers the largest portion of health care costs for the elderly and disabled

19 Dorfman M.; Introduction to Risk Management and Insurance, Pearson Education, New Yersey, 2005 pp. 447-449.

20 Folland S., Goodman A., Stano M.; The Economics of Health and Health Care, Prentice Hall, New Jersey, 2001.

21 Rejda G.; Principles of risk management and insurance, Harper Collins, New York, 2001, pp. 480-502.

persons with low income. Under the fourth program, compensated are the costs of the elderly for their hospitalization. Medicaid program enables the use of main health services, such as: vaccination of children, medical examinations, hospital treatment, etc. The Government ensures adequate level of health services and equity of beneficiaries regarding the coverage of costs. In addition, it can also define the duration of health services (for example, the number of monthly visits to the doctor's office may be limited) etc.

The most represented health insurance plans under which beneficiaries of health care programs may use health care services are HMO plans (health maintenance organization) and PPO plans (preferred provider organization).

HMO plans appeared in 1960s (and have been particularly represented since 1973, when the Congress adopted the Health Maintenance Organization Act) and they relate to the health care provided within health care institutions.[22] Insurance beneficiary pays relatively low monthly premiums and has a right to use a comprehensive package of health care services. The Law defines that the employers with 25 and more employees, must include these employees in any of HMO plans. Medical services are primarily provided by general practitioners. The insureds may not use the services of other institutions unless HMO is bound to such institutions by the contract (except in emergency events). Visiting a specialist doctor is not allowed without a referral. There are three types of HMO plans:

1. a so-called Staff Model according to which doctors of different specializations work for the HMO as permanently employed;
2. a so-called Group Model according to which the HMO does not employ physicians directly but contracts with multi-specialty physician group practice (doctors are paid per examined patient);
3. a so-called Independent Practice Association according to which physicians working within their doctor's offices provide services within HMO (they are paid for the provided service by the Association and not by the patients).

PPO plans are more flexible compared to HMO plans. In their participation in PPO plans the insureds can choose a health care institution included in PPO plan, whereas for the health care institutions not covered by the PPO plan, the medical expenses are partly covered. Examinations by the specialist doctors may be performed without a referral. Often, before using health care services, the insureds are required to pay initial annual expenses (annual deductibles) and subsequently, the insurance company is obliged to compensate the expenses under the contract.

22 www.ehealthinsurance.com

Conclusion

Generally, the health care system in the USA boasts modern medical technology, highly skilled staff and well-equipped health care institutions. High amounts of funds are spent on the health care system, whereas life expectancy is lower compared to that in a particular number of developed countries. The results of the majority of researches have shown that the health of population is mostly influenced by genetics, economic and social environment, lifestyle, and development level of health care system. To achieve a higher level of health and life expectancy, it is necessary to implement reform processes and re-channel the funds for health care. There is a large number of persons not covered by health insurance system. In the USA, private health insurance is the most represented type of insurance through which health care is delivered, with the highest participation of employer-provided health insurance plans. This type of health insurance represents an economic category. In addition to this type of health insurance, there are also public health care programs, among which the most popular are health care for the elderly, afforded through Medicare program, and health care for the poor, delivered through Medicaid program, which largely represents a social category. The introduction of mandatory health insurance in 2010 was aimed at increasing the number of insureds i.e. at cutting the number of uninsured persons and raising the health level of the entire nation. The future will show more clearly whether government incentives and health insurance market mechanisms will create the same impact on the provision of more adequate health service and more extensive coverage of insureds. As already mentioned, it is necessary to channel high amounts of funds allocated for health care to strengthening the quality of health services and distributing such quality evenly among the U.S. countries, that is, it will be necessary to ensure a high level of health care efficiency. In the majority of European countries, public health insurance is prevalent and supplemented by private health insurance, whereas in the USA, the most popular is private health insurance with the application of public health care programs and mandatory health insurance, which has been implemented for several years now. The USA, as other countries in the world, define their health care system which, according to the decision-makers, is best suited to their economic and social circumstances of work and living. Any measures aimed at strengthening health care quality, raising the level of health, and providing more extensive coverage of population will certainly be welcomed by the stakeholders in this important system.

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