

# BACKGROUND ON THE US HEALTHCARE SYSTEM

## Learning Objectives:

After completing this chapter, the student will

- have a basic understanding of the scope of the healthcare industry,
- understand how Americans pay for healthcare, and
- learn to identify the unique market characteristics of the healthcare industry.

## Background on the US Healthcare Industry

Healthcare represents a collection of services (e.g., provider visits, surgery, imaging), products (e.g., X-ray machines, drugs), institutions (e.g., hospitals, clinics, labs, insurance companies), and people (e.g., providers, technicians, researchers, administrators) that account for more than 18 percent of US gross national product (Centers for Medicare & Medicaid Services 2023). In other words, US consumers spend roughly \$1 out of every \$6 on healthcare, mostly on hospitals (37.8 percent) and physician services (27.6 percent) (Kaiser Family Foundation [KFF] 2023a). In addition, more than 11 percent of the nation's workforce currently works in the healthcare sector (Nunn, Parsons, and Shambaugh 2020), and that proportion is expected to grow as the population ages and its healthcare needs intensify.

Nearly everyone has interacted with the healthcare sector. Most people are born in hospitals, require check-ups and vaccinations before starting school, and at different points in their lives endure health events that require medical intervention. Often those interventions are expensive. A complex private–public system has developed over time to pay for that care, commonly referred to as *healthcare coverage* or *health insurance*.

In 2021, 91.4 percent of Americans had some form of comprehensive healthcare coverage, either health insurance, employer-sponsored coverage, or government-provided coverage, leaving 8.6 percent (28 million people) uninsured and paying directly for their own healthcare. Almost half the

population (48.5 percent) received coverage through their employer, with an additional 6.1 percent purchasing insurance on a state or federal exchange or directly through a commercial insurance company (KFF 2023b). Other types of insurance are plans purchased by a company or person to limit their financial exposure in case of an unexpected event. For example, people purchase car insurance to protect against the cost of repairs after an accident. Health insurance began with the same concept but has evolved to cover expected and routine care as well as unexpected illnesses or injuries.

Employers who pay for healthcare coverage for their employees, and often their employees' families, may do so either by purchasing an insurance plan or by "self-funding" (termed *self-funded plans*) or "self-insuring." In self-funded plans, employers take on the responsibility and financial risk of paying for employee healthcare costs. The employer typically hires a company, called a third-party administrator, to run the day-to-day operations of the plan. In contrast, when an employer purchases health insurance (termed *fully insured plans*), financial risk is shifted to the insurer; the employer pays a fixed monthly amount per employee for coverage, regardless of the medical expenses employees incur.

### **What Is a State or Federal "Exchange"?**

Health insurance exchanges are state or federal online marketplaces where consumers can purchase health insurance plans that best meet their needs. Established under the Affordable Care Act of 2010 (ACA), exchanges are intended to help individuals and small businesses choose among standardized plans. Federal subsidies are offered to qualified individuals through the exchanges.

Slightly more than a third of the population benefits from government-provided health insurance. For example, 21 percent qualifies for Medicaid or the Children's Health Insurance Program, which are joint federal and state programs that provide health coverage for low- and middle-income Americans. About 14 percent of the population is covered by Medicare, a federal program that provides health insurance for people aged 65 or older, with additional eligibility for individuals with specific disabilities and diseases. (See appendix A for the types of Medicare and corresponding eligibility.) Some individuals are eligible for both Medicare and Medicaid ("dual eligibles"); they are often among the most vulnerable Americans. Last, a small proportion of the population (1.3 percent) receives government health insurance through the military (KFF 2023b).

## Healthcare Market Characteristics

The healthcare sector is genuinely unique. Kenneth Arrow, a Nobel Prize-winning economist, was one of the first to highlight the many ways in which healthcare is unlike any other economic sector (Arrow 1963). In most well-functioning markets, both buyers and sellers have complete information about the goods or services they are exchanging. This arrangement is rarely the case in the healthcare market, where uncertainty and information asymmetry dominate the landscape. For consumers, the decision to buy healthcare often results from an unpredictable, random event (e.g., a car accident, abdominal pain). Shopping around for the best medical deal is not the norm; even when consumers do, they often find assessing the quality of the needed medical product or service impossible. Unlike when they buy a car or book, patients purchase medical care with great uncertainty and limited information. Although providers know far more than patients, diagnosis and treatments are still uncertain, and recovery can be unpredictable. Few other goods or services carry such high stakes (sometimes life or death), yet the buyer relies on the altruism, goodwill, and honesty of the seller. Given the uncertainty, information asymmetry, and high stakes, the need for significant regulation and oversight of provider licensing, scope of practice, and safety and quality measurement is not surprising.

### What Is Information Asymmetry?

*Information asymmetry* is an economic term that refers to a situation in which one party in a transaction has more material information than another. This imbalance of knowledge can produce inefficient outcomes. For example, in healthcare, patients neither possess nor can easily acquire the medical information necessary to ascertain appropriate treatment options; they must rely on healthcare professionals to act in their best interest. If providers are financially incentivized to offer more services, and patients cannot distinguish between necessary and unnecessary care, information asymmetry can lead to the overprovision of healthcare. Not surprisingly, information asymmetry is often a justification for regulation.

In the healthcare market, unlike most other industries, patients (and even many providers!) rarely know the price for the service purchased; in most encounters, a third party (the insurer) foots part or all of the bill. The mere presence of insurance means that patients are insulated from the true cost of care, which can drive up demand for goods and services and further

increase healthcare expenditures (a concept economists call *moral hazard*). Providers, paid on a fee-for-service basis and reimbursed by a third party, may also be incentivized to provide more services, again adding cost to the system. Few if any other markets function this way. Given rising healthcare costs, these market imperfections and perverse incentives may explain why government payers have renewed their focus on reforming how healthcare providers are paid.

Information asymmetry and uncertainty also plague insurance markets. Buyers of health insurance know far more about their health risk than insurance companies and may have an incentive to conceal their true risk to pay lower premiums. For example, who wants to acknowledge their bungee-jumping pastime to their insurance carrier? Sellers of insurance have a financial incentive to positively select healthy people. If unchecked, this incentive may result in reduced or denied coverage for those who need high-cost healthcare. Regulation provides that check; regulatory bodies intervene to ensure that insurance access is widespread, provider networks are adequate, and essential services are covered.

In addition, healthcare is flooded with externalities, instances where someone not involved in the transaction benefits or is harmed. For example, vaccinated individuals confer benefits on others by slowing the spread of disease, and drug use imposes costs on society through violence to others. The existence of externalities often leads to what economists call *market failures*: conditions where free markets, left on their own, provide either too little or too much of a good. Achieving an efficient outcome may require government intervention (e.g., public subsidization of vaccinations, legal restrictions on drug usage).

Last, many (although not all) markets operate in a competitive environment where prices are determined by the free interaction of many buyers and sellers. In healthcare, there are commonly few sellers of a medical product or service—or even just one. Higher prices, fewer transactions, and slower diffusion of innovation often characterize these imperfect or monopolistic markets. As a result, US government entities such as the Department of Justice, the Federal Trade Commission, or state regulatory bodies may intervene to encourage competition or regulate prices.

## Impacts of Tax Status

The tax status of a healthcare entity affects how it operates. In the United States, healthcare entities, insurers, or provider organizations may be non-profit, for-profit, or governmental. A for-profit entity pays property tax and state, federal, and local income tax; its purpose is to earn profits for the owners and investors, who are paid dividends. A nonprofit entity is defined as a

charity by the Internal Revenue Service and does not pay taxes. In exchange for this tax-exempt status, the entity is expected to provide a community benefit, as detailed later in this chapter. Nonprofit entities have no owners or investors and must reinvest excess revenue into the organization. (Other differences between for-profit and nonprofit are detailed in exhibit 1.1.) Governmental healthcare organizations are controlled by the local, state, or federal government; an example of the last would be Veterans Administration hospitals.

	<b>Nonprofit</b>	<b>For-Profit</b>
Donations/investments	May seek funds from individuals, foundations, and corporations that expect their funds to make a social impact. Contributors do not/should not receive a personal financial reward. Such donations are tax deductible.	May raise money from private investors who expect a personal financial return on their investment.
Taxation status	Tax exempt. Pays no federal, state, or local taxes, including property tax.	Not tax-exempt. Pays federal, state, and local taxes, including property tax.
Ownership status	Corporate entity; not owned.	Owned by private investors or publicly owned by shareholders.
Community benefit (hospitals only)	Must demonstrate community benefit in accordance with state and federal guidelines, as required by the Internal Revenue Service.	No community benefit requirement.
Financial assistance policies (hospitals only)	Must have a written financial assistance policy that limits prices to those customarily charged to insurers.	Not required.
Billing (hospitals only)	Must not engage in extraordinary collections processes; must determine if patients are eligible for financial assistance.	Not required.

**EXHIBIT 1.1**  
Characteristics  
of Nonprofit  
and For-Profit  
Healthcare  
Organizations

Source: Cheney (2019); Internal Revenue Service (2022).

The tax-exempt status of the US nonprofit healthcare enterprise has been under rising scrutiny over the past few decades. Estimated at \$28 billion for 2020 (Godwin, Levinson, and Hulver 2023), policymakers increasingly have asked if the public receives corollary benefits that outweigh the lost opportunities taxation could yield (Levinson 2023).

Section 501(r) of the Internal Revenue Code was enacted as part of the ACA to address this issue. Under this section, hospitals were required to engage in a formal Community Needs Assessment every three years and meet requirements related to financial assistance and collections. The aim was to ensure that nonprofit hospitals support people in their community in exchange for reduced taxation so the community is not disadvantaged by a diminished tax base. (See Rosenbaum, Byrnes, and Hurt [2023] for a detailed description of the history of organizational tax-exempt status and its relationship to the ACA and community benefit).

Bai and colleagues (2021) have found that for-profit and nonprofit healthcare yield about the same amount of charity care. They conclude that nonprofit and governmental charity-care provision “is not aligned” with the “charity care obligations” that stem from their tax-exempt status. Others have argued for the need to revise the standards and the process to ensure community benefit (e.g., Letchuman, Berry, and Bai 2022). Notably, recent evidence suggests that between 2012 and 2019, nonprofit hospitals with a growth in surplus (or “profit”) did not increase their provision of charity care, despite rising cash reserves. For-profit hospitals, however, did allocate increased profits on greater charity care spending, likely because of its tax deductibility (Jenkins and Ho 2023).

## Conclusion

The US healthcare system is complex. In this chapter, we have explored how market dynamics and tax status shape the system. Because governments craft healthcare regulations to solve problems caused by market failures, understanding these issues is essential.

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