

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-17

Subject: Health Care Financing Models

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1 At the 2016 Annual Meeting, the House of Delegates adopted Policy D-165.936, “Updated Study  
2 on Health Care Payment Models,” which asked that the American Medical Association (AMA)  
3 research and analyze the benefits and difficulties of a variety of health care financing models, with  
4 consideration of the impact on economic and health outcomes and on health disparities and  
5 including information from domestic and international experiences. The Board of Trustees  
6 assigned this item to the Council on Medical Service for a report back to the House of Delegates at  
7 the 2017 Annual Meeting.

8  
9 This report, which is provided for the information of the House of Delegates, provides background  
10 on varying models of health system financing; outlines the role of patient out-of-pocket payments  
11 in such systems; describes the range of roles private health insurance plays in health care financing;  
12 reviews the diversity of approaches used for provider payment; highlights the impact of health care  
13 financing models on health status and disparities; and summarizes relevant AMA policy.

## 14 MODELS OF HEALTH SYSTEM FINANCING

15  
16  
17 Health systems in general have four significant roles: to collect revenue, to pool funds, to purchase  
18 services and to provide services. Depending on the country and health system design, revenue can  
19 be collected in the form of taxes, premiums and other contributions from individuals to payers,  
20 which can include governments, private insurers and employers. Revenues collected are pooled and  
21 ultimately used to pay physicians, hospitals and other providers for services provided to covered  
22 patients, with patient cost-sharing sometimes also being required. Health systems also have a role  
23 in implementing strategies in order to ensure the safety and quality of care provided.

24  
25 As outlined in the appendix, various mechanisms are used to finance health systems, including  
26 taxation, government funding, private insurance and patient out-of-pocket payments. How  
27 countries finance health care, as well as the level of funding allocated to health care and other  
28 social services, impacts health care quality, health outcomes and health disparities. While health  
29 system financing varies from country to country, countries can fall into one overarching financing  
30 model, with some countries, including the United States, incorporating multiple financing models  
31 in their health systems. Such models include a single payer system financed through taxes;  
32 employer-sponsored insurance and coverage provided by non-profit, private insurers; and direct  
33 payments by patients for medical services, without a widespread health insurance system in place.

34  
35 Many countries finance their health systems generally through taxes, with the government serving  
36 as single payer. Partly as a result of the level of health care benefits provided by the government,  
37 countries with single payer systems tend to have higher tax rates and social insurance contributions.  
38 Overall, taxes that fund social insurance programs are often higher in other developed countries  
39 than in the United States. Various tax revenues are used to finance single payer systems. While  
40 some governments use general taxation, other governments use taxes earmarked for health care,

1 payroll taxes and other tax types. For example, in Denmark, health care is financed predominantly  
 2 through a national health tax, equal to eight percent of taxable income.<sup>1</sup> In the United Kingdom, the  
 3 majority of financing for the National Health Service comes from general taxation and a payroll  
 4 tax.<sup>2</sup> In Canada, provinces and territories administer their own universal health insurance programs,  
 5 with financing predominantly coming from general provincial and territorial spending.<sup>3</sup> Italy's  
 6 National Health Service is financed primarily through a corporate tax and a defined portion of  
 7 national value-added tax revenue.<sup>4</sup>

8  
 9 Other countries have employer-sponsored insurance and coverage provided through non-profit,  
 10 private insurers. For example, health insurance in Germany is mandatory for all citizens and  
 11 permanent residents, and is primarily provided by competing "sickness funds," not-for-profit,  
 12 nongovernmental health insurance funds. Sickness funds are financed by mandatory contributions  
 13 imposed as a percentage of employees' gross wages up to a ceiling. High-income individuals can  
 14 choose to opt out and instead purchase substitutive private coverage.<sup>5</sup> Switzerland requires  
 15 residents to purchase mandatory statutory health insurance, which is offered by competing  
 16 nonprofit insurers. Direct financing for health care providers, predominantly for hospitals providing  
 17 inpatient acute care, comes from tax-financed government budgets. Residents pay premiums for  
 18 statutory health insurance coverage; premiums are redistributed among insurers by a central fund,  
 19 adjusted for risk.<sup>6</sup>

20  
 21 In the Netherlands, all residents are required to purchase statutory health insurance from private  
 22 insurers. Its statutory health insurance is financed through a combination of a nationally defined,  
 23 income-related contribution; a government grant for insured individuals below age 18; and  
 24 community-rated premiums set by each insurer. Such contributions are collected centrally and  
 25 allocated to insurers according to a risk-based capitation formula.<sup>7</sup> In Japan, the universal public  
 26 health insurance system, which includes more than 3,400 insurers, is funded by premiums, tax-  
 27 financed subsidies and user charges.<sup>8</sup> In France, the predominant sources of funding for statutory  
 28 health insurance provided to all residents are employer and employee payroll taxes, with  
 29 contributions also from a national earmarked income tax; taxes assessed on tobacco, alcohol, the  
 30 pharmaceutical industry and voluntary health insurance companies; state subsidies; and transfers  
 31 from other branches of Social Security.<sup>9</sup>

32  
 33 Singapore offers universal health care coverage to its citizens, financed by government subsidies,  
 34 multilayered financing arrangements, and individual medical savings accounts. Government  
 35 subsidies cover up to 80 percent of the total bill at public health care institutions. All Singapore  
 36 citizens and permanent residents are covered by MediShield Life, which is a basic health insurance  
 37 plan that helps individuals pay for hospital and select, high-cost outpatient expenses. Low- and  
 38 middle-income individuals and families receive premium subsidies funded by the government to  
 39 afford coverage. MediShield Life premiums may be fully paid from Medisave, which is a  
 40 mandatory medical savings program. Medisave contributions can also be used for expenses  
 41 associated with hospitalization, day surgery and certain outpatient services. Medisave requires most  
 42 workers to contribute 8 to 10.5 percent, depending on age, of their monthly salary to a personal  
 43 Medisave account, with matching contributions from employers. The Medisave contribution rates  
 44 of low-income workers are based on a range of phased-in contribution rates. Individual  
 45 contributions to and withdrawals from Medisave accounts are tax-exempt.<sup>10,11,12</sup>

46  
 47 **THE ROLE OF PATIENT OUT-OF-POCKET PAYMENTS**

48  
 49 The role of patient out-of-pocket payments in contributing to health care financing varies. In  
 50 Canada, there is no patient cost-sharing for publicly insured physician, diagnostic and hospital  
 51 services.<sup>3</sup> Likewise, in Denmark, there is no cost-sharing for hospital and primary care services.<sup>1</sup> In

1 the United Kingdom, there is limited cost-sharing for publicly covered services; patient out-of-  
2 pocket responsibilities are mainly limited to services that fall outside the purview of the National  
3 Health Service.<sup>2</sup> In Israel and Italy, there is no cost-sharing for primary care visits or for hospital  
4 admissions.<sup>4,13</sup> In these countries where for many services patients have no cost-sharing, patients  
5 may have out-of-pocket responsibilities for outpatient prescription drugs, dental care and vision  
6 care. In many cases, vulnerable groups in these countries are either exempt from or face lower  
7 prescription drug copayments.

8  
9 In the United States, on the other hand, deductibles and cost-sharing provisions can be significant,  
10 and vary based on the health plan in which patients are enrolled. For the half of the US population  
11 enrolled in employer-sponsored coverage, it is common to have a general annual deductible for  
12 coverage. Eighty-three percent of covered employees are enrolled in a plan with a general annual  
13 deductible for single coverage; the average deductible for single coverage was \$1,478 in 2016.  
14 Individuals covered by employer-sponsored coverage also face cost-sharing requirements. In  
15 general, roughly two-thirds of covered employees have copayment responsibilities for primary care  
16 and specialist physician visits, whereas a quarter has coinsurance. Among covered employees with  
17 copayments for in-network physician visits, the average copayment was \$24 for primary care and  
18 \$38 for specialty physician office visits in 2016. The average coinsurance rates for employees with  
19 coinsurance responsibilities for in-network physician office visits in 2016 were 18 percent and 19  
20 percent for primary care and specialist physician office visits respectively.<sup>14</sup>

21  
22 Relevant to both employer-sponsored and plans offered on health insurance exchanges, the  
23 Affordable Care Act (ACA) requires non-grandfathered health plans to have an out-of-pocket  
24 maximum of \$7,150 or less for single coverage and \$14,300 for family coverage in 2017.<sup>15</sup> In  
25 2016, the median individual deductible for health plans offered in states using the HealthCare.gov  
26 platform was \$850. That being said, the median average deductible for bronze plans (covers 60  
27 percent of benefit costs) in states using HealthCare.gov, in which 21 percent of HealthCare.gov  
28 exchange enrollees were enrolled, was \$6,300.<sup>16</sup> Cost-sharing subsidies are available to individuals  
29 and families with incomes between 100 and 250 percent federal poverty level (FPL) (133 and 250  
30 percent FPL in Medicaid expansion states) who enroll in a silver plan (covers 70 percent of benefit  
31 costs). Cost-sharing subsidies effectively raise the actuarial value (percent of benefit costs covered)  
32 of the silver plan, leading patients to face lower deductibles, out-of-pocket maximums, copayments  
33 and other cost-sharing amounts. For publicly insured individuals, while Medicare requires  
34 deductibles for hospital stays and ambulatory care and copayments for physician visits and other  
35 services, Medicaid requires minimal cost-sharing.

36  
37 Residents of Switzerland have similar types of cost-sharing exposures as privately-insured  
38 individuals in the US. Insured individuals are responsible for deductibles for statutory health  
39 insurance coverage, which can be lower, closer to \$200, or higher, more than \$1,800, depending on  
40 patient choice. After the deductible is met, individuals pay 10 percent coinsurance for all services  
41 up to an annual maximum of more than \$500 for adults, with the cap for children being roughly  
42 half of that for adults. Low-income individuals are eligible for premium subsidies, and regional  
43 governments or municipalities cover the health insurance expenses of individuals receiving social  
44 assistance benefits or supplementary old age and disability benefits.<sup>6</sup> Residents of Singapore face  
45 cost-sharing responsibilities that are often higher than many other countries. Copayments after  
46 government subsidy and applicable MediShield Life coverage can be paid by individual medical  
47 savings accounts and/or cash. In addition, Singapore's safety net program covers medically  
48 necessary treatment, based on patient and family income, medical condition and treatment costs.  
49 Often, all outstanding treatment costs for disadvantaged individuals are covered.<sup>10</sup>

1 In Japan, while there are no deductibles, most enrollees pay a 30 percent coinsurance rate for health  
2 care services and goods, with children under age three and adults ages 70 and older with lower  
3 incomes subject to lower coinsurance rates. There are catastrophic coverage limits on monthly out-  
4 of-pocket spending according to enrollee age and income. There are also subsidies and lower  
5 coinsurance rates based on income for patients with designated chronic conditions, mental illness  
6 and disabilities.<sup>8</sup>

7  
8 Overall, several other countries, while requiring deductibles and/or copayments, also impose caps  
9 on cost-sharing, which limit patient out-of-pocket responsibilities. There are also exemptions from  
10 cost-sharing for vulnerable populations. For example, in Germany, there is an annual cap on cost  
11 sharing for adults equal to two percent of household income; the cap is equal to one percent of  
12 household income for chronically ill individuals.<sup>5</sup> In Sweden, annual out-of-pocket payments for  
13 health care visits are capped below \$200.<sup>17</sup>

#### 14 15 THE ROLE OF PRIVATE HEALTH INSURANCE

16  
17 Private insurance can play a complementary, supplementary and/or substitutive role to public  
18 health insurance options. Based on the country, premiums for private coverage can be paid by  
19 individuals and/or employers, unions or other organizations. Complementary insurance, available  
20 in several countries, covers services that are excluded or not fully covered in the statutory plan,  
21 which could include prescription drug, dental and/or vision coverage. The United States has a  
22 version of complementary insurance in the Medicare program; Medicare supplemental plans  
23 provide various levels of complementary coverage for individuals enrolled in original Medicare.  
24 Supplementary insurance builds off the statutory coverage provided to improve coverage and can  
25 provide increased choice of or faster access to providers. For example, private health insurance in  
26 Australia and Norway offers more choice of providers, as well as expedited access to  
27 nonemergency care.<sup>18,19</sup>

28  
29 Substitutive insurance is duplicative of coverage offered in the statutory plan, and could be  
30 available to populations not covered by or those who opt out of the statutory plan. In Germany,  
31 many young adults with higher incomes take advantage of substitutive private health insurance,  
32 because health insurers offer them coverage for a more extensive range of services, as well as  
33 lower premiums.<sup>5</sup> On the other hand, in Italy, citizens and legal residents cannot opt out of the  
34 National Health Service; as such, private health insurance can only be complementary and/or  
35 supplementary in nature.<sup>4</sup> In the United States, Medicare Advantage can be thought of as  
36 substitutive to original Medicare.

#### 37 38 APPROACHES TO PROVIDER PAYMENT

39  
40 Approaches to paying providers vary, and are not wholly dependent on a country's health care  
41 financing model. Physicians can be salaried, or be paid via fee-for-service and capitation. Payments  
42 to physicians can also depend on whether patients have registered with and/or received a referral  
43 from their primary care physician. Physician fee schedules can be regulated or set by national,  
44 regional or local health authorities, negotiated between national medical societies/physician trade  
45 unions and the government, or negotiated/set by sickness funds or health plans. Physicians in some  
46 countries can also receive performance-based payments. Patient out-of-pocket payments contribute  
47 varying levels to physician payment, depending on cost-sharing responsibilities.

48  
49 Hospital financing can depend on whether hospitals are public, private, nonprofit or for-profit.  
50 Public hospitals can operate under a global budget determined by the responsible health authority,  
51 or receive a majority of their funding from federal, regional or local governments. Both public and

1 private hospitals can receive funding from health insurer compensation, as well as patient out-of-  
 2 pocket payments. In many countries, diagnosis-related group (DRGs) or similar systems inform  
 3 hospital payment levels.

4  
 5 **IMPACT ON HEALTH STATUS**

6  
 7 Health care financing models can impact population health status based on how health care dollars  
 8 are distributed, how health care spending affects other spending on social services and other  
 9 factors. While the United States surpasses its peers on health care spending, both as a percentage of  
 10 gross domestic product and per capita spending, some data indicate that this has not led to better  
 11 health outcomes for the population as a whole. Americans have fewer physician and hospital visits  
 12 than residents of many countries highlighted in this report. At the same time, Americans tend to be  
 13 greater consumers of medical technology, including diagnostic imaging and pharmaceuticals, and  
 14 pay the highest prices for physician and hospital services, as well as prescription drugs.<sup>20</sup> These  
 15 differences in prices largely are the result of the majority of the US health care system being  
 16 market-based in nature, versus the government influencing prices and health care costs.

17  
 18 While governments can have a role in the prices paid for health care services and pharmaceuticals,  
 19 as well as health care budgets, there sometimes is a negative impact of such government  
 20 intervention and funding on access to needed hospital and physician services, as well as  
 21 prescription drugs. Such impacts can include prescription drugs not being on a national formulary,  
 22 wait times for medically necessary physician services and hospital procedures, and medical  
 23 innovations not being made available to patients. In the United States, such issues have been  
 24 recently experienced by patients in the Veterans Health Administration. Presently, due to system  
 25 underfunding, the National Health Service in the United Kingdom is experiencing hospital  
 26 overcrowding, with reports of operations being canceled.<sup>21,22,23</sup>

27  
 28 **HEALTH CARE DISPARITIES**

29  
 30 The distribution of health care finances and health professionals, as well as variations in health  
 31 insurance coverage, can impact health care disparities. On the whole, health disparities exist  
 32 between insured and uninsured individuals. In countries with universal coverage, such disparities  
 33 are evident in the undocumented immigrant population. In several countries, including the US and  
 34 those that offer private, voluntary health insurance in addition to statutory health insurance, health  
 35 disparities, and disparities in access, can result from variations in health insurance benefit  
 36 packages. Disparities also result from whether or not patients have additional private coverage. In  
 37 some countries including Australia, having private health coverage varies by socioeconomic  
 38 status.<sup>18</sup> In France, individuals who did not have complementary insurance reported poorer health.<sup>9</sup>

39  
 40 Income-related health disparities in self-reported health status exist in several countries, including  
 41 the United States, Italy and the Netherlands.<sup>4,7</sup> Geographic disparities also exist, which are  
 42 sometimes the result of how health care is financed. For example, in Italy, there are geographic  
 43 disparities based on region, and interregional equity has long been a concern based on the  
 44 economic differences between the regions of the country. While taxes received for health care are  
 45 pooled nationally and redistributed back to the regions, the funding in some regions for health care  
 46 remains insufficient. The funding disparity is exacerbated by the ability of regions to contribute  
 47 additional revenue toward health care.<sup>4</sup> Similarly, health disparities also exist between prefectures  
 48 of Japan.<sup>8</sup>

49  
 50 Rural/urban, and racial and ethnic health disparities are common, as are disparities across  
 51 socioeconomic groups. For example, in the Netherlands, there is a difference of up to seven years

1 in life expectancy between the highest and lowest socioeconomic groups.<sup>7</sup> In France, there is a gap  
2 in life expectancy between males in the highest and lowest social categories.<sup>9</sup> In Australia, the most  
3 prominent disparities in health outcomes are between the Aboriginal and Torres Strait Islander  
4 population and the rest of Australia's population.<sup>18</sup> In the United States, there are disparities in  
5 health status and health insurance status based on race and ethnicity, and residents of rural areas  
6 face barriers to health care.

7  
8 RELEVANT AMA POLICY

9  
10 Policy H-165.985 supports free market competition among all modes of health care delivery and  
11 financing, with the growth of any one system determined by the number of people who prefer that  
12 mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.  
13 Policy H-285.998 reaffirms that the needs of patients are best served by free market competition  
14 and free choice by physicians and patients between alternative delivery and financing systems.  
15 Policy H-165.920 supports pluralism of health care delivery systems and financing mechanisms in  
16 obtaining universal coverage and access to health care services.

17  
18 CONCLUSION

19  
20 The AMA has long supported pluralism of health care financing mechanisms to obtain universal  
21 coverage and access to health care services. Importantly, the AMA also has supported free market  
22 competition among all modes of health care financing. In its analysis, the Council found that the  
23 health care financing models studied have their respective advantages and disadvantages. Some  
24 health care financing models were tied to systems of increased government regulation of prices and  
25 budgets across the health system, which undermines the free market principles that the AMA has  
26 long supported. The Council also recognizes that the diversity of health care financing models  
27 represents different country-to-country priorities, societal beliefs, and a matter of acceptable trade-  
28 offs. Such trade-offs can include the level of health insurance coverage achieved by the financing  
29 model; individual tax burdens; the level of government regulation required; and the model's  
30 support for, use of and impact on innovation in the health care system.

31  
32 Compared to the countries outlined in this report, the United States is the only country without a  
33 publicly-financed system of universal health care. At the same time, the United States surpasses its  
34 peers on health care spending, both as a percentage of gross domestic product and per capita  
35 spending. It also spends more public dollars per capita on health care than most other countries  
36 highlighted in the report. As outlined in the appendix, the level of investment of the United States  
37 on health care, and its pluralistic model of health care financing, has not necessarily translated to  
38 better health outcomes for the population as a whole. That being said, the Council recognizes that  
39 some of the differences in health outcomes between the United States and other countries may  
40 partly be the result of divergent definitions of indicators compared, as well as other factors that  
41 drive health care costs. The Council affirms that within the United States, as with any health  
42 system, improvements can be made to achieve better population health status and outcomes, and  
43 ensure the provision of quality care.

44  
45 The Council recognizes that the US health system and its mechanisms of financing are in a time of  
46 transformation and change. The United States is continuing to move forward with implementing  
47 various new and innovative payment and delivery models, which prioritize patient engagement and  
48 health outcomes. Moving forward, the Council will continue to monitor the impact of health  
49 system transformations and financing changes on coverage, access to and quality of health care,  
50 and health status and outcomes.

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**Appendix: Health Care System Financing, Coverage and Performance of Selected Countries<sup>1</sup>**

Country	% GDP, 2013	Government role	Public system financing	Role of private insurance	% adults waited 2 months or more for specialist appt, 2013	% adults experienced access barrier due to cost in past year, 2013	Avoidable deaths per 100,000 population, 2013
Australia	9.4% (2012)	Universal public medical insurance program (Medicare), national & state public hospital funding	General tax revenue; earmarked income tax	Complementary, supplementary	18%	16%	68 (2011)
Canada	10.7%	Regionally administered universal public insurance program	Provincial/federal general tax revenue	Complementary	29%	13%	78 (2011)
France	11.6%	Statutory health insurance system, insurers in national exchange	Employer/employee earmarked income and payroll tax; general tax revenue; earmarked taxes	Complementary, supplementary	18%	18%	64 (2011)
Germany	11.2%	Statutory health insurance system, insurers in national exchange; high income can opt out for private coverage	Employer/employee earmarked payroll tax; general tax revenue	Substitutive, complementary, supplementary	10%	15%	88
Netherlands	11.1% <sup>2</sup>	Statutory health insurance system with universally-mandated private insurance, regulated and subsidized by government	Earmarked payroll tax; community-rated premiums; general tax revenue	Complementary	3%	22%	72
New Zealand	11.0%	National health care system	General tax revenue	Complementary, supplementary	19%	21%	89 (2011)
Norway	9.4%	National health care system	General tax revenue; national and municipal taxes	Supplementary	26%	10%	69
Sweden	11.5%	National health care system, with responsibility for most financing devolved to county councils	General tax revenue raised by county councils; national tax revenue	Supplementary	17%	6%	72
Switzerland	11.1% <sup>2</sup>	Statutory health insurance system, with universally mandated private insurance, with state government responsible for financing through subsidies	Community-rated insurance premiums; general tax revenue	Complementary, supplementary	3%	13%	n/a
United Kingdom	8.8%	National health service	General tax revenue	Supplementary	7%	4%	86
United States	17.1%	Insurance coverage mandated, with some exceptions; Medicare; Medicaid; subsidies for health insurance exchange coverage	Payroll tax, federal and state tax revenues, premiums	Individual and employer-sponsored, Medicare supplemental	6%	37%	115 (2010)

<sup>1</sup> Excerpted from 2015 International Profiles of Health Care Systems. The Commonwealth Fund. January 2016.

<sup>2</sup> Current spending only, and excludes spending on capital formation of health care providers.