Comparing Health Systems: United States and Germany

The health insurance systems in the United States and Germany share many similarities, but also have key differences. This document provides an overview of the primary features of these two health insurance systems and analyzes the commonalities and differences between them.

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United States

Coverage

Most Americans receive their health insurance coverage through their employer.[1]

Following the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, all individuals were required to purchase health insurance.[2] However, the penalty for noncompliance was nullified in 2017.[3]

Dependents may enroll in their parents' health insurance plan through the age of 26.[4]

If an individual earns less than a certain amount of money per year, he or she may become eligible for Medicaid coverage, which is heavily subsidized by the federal government.[5] Eligibility for Medicaid requires an individual's income to be below a percentage of the federal poverty level, with variations among states.[6]

Individuals over the age of 65 and those with End Stage Renal Disease (ESRD) are eligible for Medicare coverage, which is also heavily subsidized by the federal government.[7]

ACA Marketplace coverage is available to U.S. citizens and lawfully present non-citizens, and this coverage is subsidized by the federal government with tax credits if an individual's income is below a certain threshold.[8] Medicaid coverage is available to U.S. citizens and lawfully present non-citizens.[9] Medicare coverage is available to U.S. citizens and legal permanent residents.[10]

Premiums

Under the ACA, health insurance premiums are calculated based on age, location, category of coverage, and tobacco use.[11] Premiums are collected by private insurance companies. Insurers must dedicate a certain percentage of collected premiums towards enrollees' medical care.[12] Premiums collected beyond this threshold must be rebated back to enrollees.[13]

Benefits

Benefits for Medicare, Medicaid, and marketplace health plans are decided by the federal government and plans are required to cover those benefits.[14]

States may adjust the benefits provided by Medicaid as long as they remain within federal guidelines.[15]

Marketplace plans may elect to provide benefits beyond those mandated by the government. For marketplace plans, dental benefits for children are mandatory, while dental benefits for adults are optional.[16]

Large employers and self-funded plans are not required to cover the federally-mandated benefits, but they are assessed a penalty if their plans do not provide a minimum value to their enrollees.[17]

Individuals may elect to enroll in a private Medicare Advantage plan, which can offer additional benefits beyond those covered by Original Medicare.[18]

Drug Pricing

Drugs are approved by the U.S. Food and Drug Administration (FDA) based on their safety and efficacy.[19] Once a new drug is granted approval by the FDA, the manufacturer is typically granted market exclusivity and patent protection, which allows them to sell their product in the U.S. without competition for a set number of years, depending on the type of product.[20]

Market exclusivity gives manufacturers wide latitude to decide the prices that they will charge for their drug products, subject to negotiation with pharmacy benefit managers.[21] Enrollees in marketplace plans and employer-sponsored plans obtain drugs based on this negotiated price, with the plan paying most of the cost and the individual being responsible for cost-sharing in the form of a copayment or coinsurance.[22] These out-of-pocket costs are typically paid at the pharmacy.[23]

Manufacturers must sell their drugs to state Medicaid programs using the best price offered to any purchaser, with an additional rebate further reducing that price.[24]

Medicare reimburses providers for purchasing drugs that must be administered in an office setting, based on the average sales price of the drug plus a percent-based add-on to cover administrative expenses and overhead.[25] For drugs that enrollees access through a pharmacy, Medicare pays Part D plans a percentage of the drug cost that the plans negotiate with manufacturers, with the remainder being paid by beneficiaries through Part D plan premiums and cost-sharing.[26]

To contain the costs of expensive treatments, health insurers rely on utilization management strategies to restrict enrollees' access to these treatments.[27] These utilization management strategies insert insurers into the patient-practitioner relationship and create barriers to treatment.[28] Drug utilization is managed by insurers to control costs, but it can create care delays that can jeopardize patients' health outcomes.[29]

Cost-sharing

Patients must pay most health care costs until they reach their deductible.[30] Once the deductible is reached, the health plan contributes a larger share towards covered services.[31]

In all plans except for those that existed before the ACA was implemented, preventive services are provided at no cost to the individual.[32]

Cost-sharing is capped at a certain amount, known as the maximum out-of-pocket threshold; once this threshold is met, the health plan pays 100% of all costs for in-network covered services.[33] Non-covered services may be obtained by individuals who choose to pay for them out-of-pocket.

The federal government collects funds from all types of health plans and redistributes the money among marketplace health plans using risk-adjustment to ensure that costs are stable and to avoid adverse selection in health insurance risk pools.[34] This approach takes money from health plans that have healthier risk pools and reapportions them to health plans that have sicker risk pools.

The ACA implemented a temporary reinsurance program that helped to stabilize costs in the individual market while some consumers obtained health coverage for the first time.[35] This reinsurance program provided additional federal payments to insurers who covered enrollees with high health care costs, which prevented those high-cost enrollees from causing sharp increases in costs for other plan enrollees.[36] After this program expired in 2016, some states have elected to enact similar arrangements using a combination of state and federal funds.[37]

Payment

Insurers negotiate in-network payment rates with health care providers.[38] Payment rates are not set by the government. Health plan enrollees typically pay these negotiated rates until they satisfy their deductible.[39] Individuals will typically pay more out-of-pocket if they visit a provider that is not in their health plan's network.[40]

Competition

Individuals typically have a moderate degree of choice for the health insurance plan that they would like to enroll in, but enrollees are typically restricted to a single network of providers that the health plan has contracted with.[41] Where few insurers participate in a single market, enrollees' ability to choose among different health plans is reduced.[42] Individuals obtaining coverage through their employer are typically only able to select a single insurance plan, though sometimes they may have the option of choosing among different levels of coverage from a single insurer.[43]

Germany

Coverage

All citizens and permanent residents are required to obtain health insurance.[44]

Employed individuals making less than a certain amount per year ($71.5k in 2016) are automatically covered by a non-profit "sickness fund," which provides their health insurance.[45] This is known as "statutory health insurance."[46]

Non-working dependents that live at the same address as the head of household are included in their family's statutory health insurance plan for free.[47]

If enrolled in a private health insurance plan, dependents will incur additional premium payments.[48] Individuals may choose which sickness fund they would like to enroll in.[49]

Individuals making more than the income threshold may elect to be covered by private health insurance instead, which offers more comprehensive benefits at additional cost to the individual.[50] About half of these private insurance plans are for-profit, while the rest are non-profit.[51]
Coverage through private health insurance is available to all legal residents, but not required.[52] In 2017, 87 percent of Germans were enrolled in statutory health insurance, while 11 percent were enrolled in a private insurance plan.[53]

Premiums

Premiums are calculated based on income and collected through a payroll tax deduction.[54] The payroll deduction for statutory health insurance is around 15 percent of wages, up to a threshold ($65k in 2016), which is divided equally between the employer and the employee.[55] This money is redistributed to each of the sickness funds based on risk-adjustment.[56] Earnings above this threshold are exempt from the payroll tax.[57] Individuals are charged a supplementary premium to cover total expenditures, on average this is 1.1 percent of their income.[58]

Benefits

Sickness funds are required by law to cover a comprehensive set of benefits, including preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, and sick leave compensation.[59]

The benefits covered by statutory health insurance are decided by the Joint Federal Committee, which is a public agency that is supervised by the Ministry of Health.[60] The membership of the Joint Federal Committee includes the National Associations of Health Insurance Physicians and Dentists, the German Hospital Federation, and the Central Federal Association of Health Insurance Funds.[61]

Home care is covered separately by Long-Term Care Insurance, which is included in either statutory or private health insurance coverage and funded through an additional payroll tax.[62]

Private health insurance plans will typically cover all of the same benefits as statutory health insurance, but these plans allow individuals to include additional benefits to suit their needs.[63]

Statutory health insurance also provides maternity pay to pregnant mothers while they are unable to work due to their pregnancy, which begins six weeks prior to the pregnancy's due date and concludes eight weeks after delivery.[64] Expecting mothers who are privately insured can receive maternity pay from the Federal Insurance Office.[65]

For a drug to be covered by statutory health insurance, it must either receive market authorization from the European Medicines Agency or market approval from the Federal Institute for Pharmaceuticals and Medical Products.[66]

Drug coverage may be excluded from coverage by law, which includes drugs to treat minor ailments, over-the-counter drugs, and lifestyle medications.[67] Individuals can obtain these medications by paying for them out-of-pocket.[68]

Drugs may also be excluded from coverage by the Joint Federal Committee if their therapeutic benefit is unproven.[69] Individuals can access treatments excluded by the Joint Federal Committee if they obtain explicit authorization from statutory health insurance.[70] With this authorization, individuals can receive coverage for the excluded treatment. Otherwise, they must pay the full cost out-of-pocket.[71]

Drug Pricing

For the first year that a drug is available following approval by the EMA, the manufacturer sets the price.[72] Thereafter, the Institute of Quality and Efficiency in Health Care (IQWiG) conducts a clinical assessment that determines the value that a drug has compared to existing treatment options.[73]

IQWiG is comprised of a Board of Directors and a Foundation Council.[74] The Board of Directors includes two members from health insurance funds, two members from provider organizations, and one representative from the Ministry of Health, while the Foundation Council is evenly split between representatives from the health insurance funds and provider organizations.[75]

Patients are able to offer their views on benefit assessments by submitting comments throughout the process.[76]

If IQWiG determines that a new drug provides additional benefit over existing treatment options, insurers collectively negotiate with the manufacturer on a price that is incrementally greater than the price of the existing treatment option, based on the comparative benefit provided by the treatment.[77] If the new drug does not provide additional benefits over the existing treatment option, the price of the drug is set to the price of the existing treatment option.[78]

If the insurers and manufacturer fail to reach an agreement on a drug's price, an arbitration board is used to set the price.[79] Manufacturers may resign from the negotiation process, which results in the drug being excluded from coverage.[80]

Cost-sharing

Patient cost-sharing is minimal, and most often takes the form of flat copayments.[81] Non-covered services may be obtained by individuals who choose to pay for them out-of-pocket.[82] Minors are exempt from cost-sharing.[83] Cost-sharing for adults is capped at 2 percent of household income; 1 percent for chronically ill.[84] Patients pay a maximum of 10 Euros for prescription drugs.[85]

Payment

Health care providers are paid on a prospective fee-for-service basis with global capitation.[86] Each year, the government sets a global budget for health expenditures and this money is apportioned among health insurers and providers regionally.[87] If utilization is higher than anticipated, payments are lowered proportionally.[88] Global caps are set by the government independently for different types of services, e.g., hospitals, ambulatory care, and pharmaceutical products.[89]

Competition

Individuals have a high degree of choice among sickness funds and enrollees are generally not restricted to certain providers or hospitals, which creates a healthy amount of competition.[90] Sickness funds compete based on the affordability of their premiums.[91] Sickness funds are permitted to engage in selective contracts with providers, which set restrictions on when enrollees can see specialists in exchange for exemption from cost-sharing and shorter wait times.[92] Sickness funds can tailor their benefits packages and cost-sharing requirements to the needs of their enrollees, which gives them another way to compete with one another.[93]

Similarities and Differences Between the U.S. and German Health Care Systems

United States	Germany
Makes coverage available to all citizens and lawfully present non-citizens. Excludes participation for undocumented immigrants.[94]	Provides coverage for all citizens and permanent residents and does not exclude participation based on citizenship.
Provides low-cost coverage to low-income individuals with cost-sharing levels determined by the states.	Provides coverage to low-income individuals with minimal cost-sharing.
Out-of-pocket costs can be high, even when coverage is provided through an employer.	Out-of-pocket costs are minimal, with contributions being made primarily through a payroll tax.
Health plans feature a maximum out-of-pocket cost limit, but only for in-network services. Cost-sharing can greatly outpace individual income, leading to medical bankruptcy.	Cost-sharing is capped at a percent of an individual's income.
Most health plans must offer a minimum set of benefits. Wealthier individuals can typically obtain more generous benefits by purchasing a more expensive plan.	All sickness funds must provide a minimum set of benefits. Wealthier individuals can obtain more generous benefits through a private health insurance plan.
Cost-sharing for in-network services is capped, and insurers increasingly use percent-based coinsurance. Cost-sharing for out-of-network services is uncapped.	Cost-sharing is typically in the form of flat copayments.
Coverage for adult dental care is optional, while coverage for pediatric dental care is required. Most plans are required to cover mental health care.	Provides comprehensive coverage for adult and pediatric dental care and mental health care.
Allows individuals to select among different health insurance plans, which typically limits the providers enrollees can see in-network.	Offers freedom of choice among sickness funds and providers.
Benefits and cost-sharing requirements can vary greatly among insurance plans, which can create inequalities in how individuals experience the health care system.	Benefits and cost-sharing requirements vary slightly among sickness funds, which leads to more consistent care delivery among individuals.
Utilizes risk adjustment to reapportion funds among commercial insurance plans to address adverse selection. Health plans provided by large employers contribute money towards risk adjustment, but they do not receive any funds in return.	Utilizes risk adjustment to reapportion funds among sickness funds to address adverse selection.
Does not effectively mandate coverage for all citizens and legal residents, leading to high rates of uninsured and underinsured individuals.	Effectively mandates coverage for all citizens and permanent residents, leading to universal coverage.
Provides access to most available treatments and services, if the individual can afford the cost-sharing requirements. Medicines are only unavailable if they are not approved by the FDA. Over the counter medications are not covered.	Provides access to treatments that have received market authorization or market approval with flat cost-sharing for individuals. Medicines are only unavailable if the manufacturer fails to negotiate with the sickness funds on a price, if coverage is excluded by law, or if coverage is excluded by the Joint Federal Committee. Individuals can access non-covered treatments if they pay the full cost out-of-pocket.

Similarities and Differences Between the U.S. Essential Health Benefits and German Sickness Funds' Mandated Benefits

United States[95]	Germany[96]
Outpatient hospital care	Outpatient hospital care
Emergency services	Emergency services
Inpatient hospital care	Inpatient hospital care
Pregnancy, maternity, and newborn care	Pregnancy, maternity, newborn care, and maternity leave[97]
Mental health, behavioral health, and substance use disorder services	Integrated mental health care, behavioral health, and substance use services
Prescription drugs	Prescription drugs covered by law
Rehabilitative and habilitative services and devices	Rehabilitative and habilitative services and devices[98]
Laboratory services	Laboratory services[99]
Preventive and wellness services and chronic disease management	Preventive services and chronic disease checkups
Pediatric services, including oral and vision care	Dental and vision care for children and adults
Sick leave may or may not be provided by employers	Sick leave provided by health insurer

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