

The Health Insurance Exchange: An Oligopolistic Market In Need Of Reform

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ABSTRACT

Until the Patient Protection and Affordable Care Act commonly known as the Affordable Care Act (ACA) was signed into law in March 2010, United States was the only industrialized rich country in the world without a universal healthcare insurance coverage. While pioneering works by Burns (1956, 1966) focused on the Social Security Act of 1935 in addressing the health insurance needs of U.S. retired population through Medicare, and later Medicaid was created by the Social Security Amendments of 1965, U.S. health insurance has remained a private, for-profit venture. The passage of ACA was one of the most contentious legislations of modern times. Soon after it was signed into law, various groups of private citizens and a number of States challenged some provisions of the ACA; however, the Supreme Court of the United States upheld its key provisions. A segment of the Congress remains opposed to the ACA on ideological ground and continues to challenge it with a variety of legal maneuvers. Notwithstanding the political or ideological arguments for or against the ACA, the objective of this paper is to analyze the competitiveness of the health insurance marketplace which opened on October 1, 2013. In doing so, the paper will address the structure of the health insurance exchange and suggest ways and means to make it more competitive.

Keywords: Health Insurance Exchange; Oligopoly; Medicare; Medicaid; Krankenkassen

INTRODUCTION

In a comprehensive study of healthcare and health insurance systems of major industrialized countries of the world, Reid (2009) documented a case of a young woman from Tennessee who had contracted systemic lupus erythematosus (lupus), and died at the age of 32 primarily because of lack of health insurance coverage. Reid's documentation highlights a major policy debate that centers around the death of a significant number of people in the United States every year due to lack of health insurance. "Nearly 45,000 people die in the United States each year – one every 12 minutes – in large part because they lack health insurance and cannot get good care" (<http://www.reuters.com/article/2009/09/17/us-usa-healthcare-deaths-idUSTRE58G6W520090917>). A similar study by Wilper, et al (2009) concludes "Uninsurance is associated with mortality. The strength of that association appears similar to that from a study that evaluated data from the mid-1980s, despite changes in medical therapeutics and the demography of the uninsured since that time." Lack of, or denial to health insurance has been a major public health concern for many years. In a widely circulated study of its member countries (191 countries reporting), the World Health Organization (WHO) in 2000 ranked United States at 54-55 (tied with Fiji) for "Fairness to Financial Contribution to Health Systems" (World Health Organization, 2000). According to that index, countries like Bangladesh, India and Tanzania ranked ahead of the United States.

The debate over private versus public coverage and management of health insurance in the United States continues both on ideological and efficiency grounds (Fuchs, 2002; Gratzner, 2006; Halvorson, 2009; Himmelstein, et al 1999 and Wilper, et al., 2009). A number of authors, mostly research physicians have advanced profit motive in treating patients in the privately funded health insurance market of the United States (Angel, 2004; Brownlee 2007; Moynihan and Cassels, 2005; Welch, et al., 2011). Yet others have debated for or against the integrity and efficiency of the private health insurance market (Ceullar, et al., 2000; Hiltz, 2003; Jonas, 1969). The most convincing argument against the U.S. health insurance system stems from the fact that the system does not cover a significant part of U.S. population, and that it is inefficient. Even after the ACA was signed into law, according to the U.S.

Census Bureau, 15.7 percent of U.S. population was without any health insurance in 2011. The percentage of population without health insurance declined by a small fraction to 15.4 percent in 2012; however, the Census Bureau observed, “the 48.0 million people without coverage in 2012 was not statistically different from the 48.6 million in 2011” (http://www.census.gov/newsroom/releases/archives/income_wealth/cb13-165.html; released on September 17, 2013). Employers often mention rising insurance costs which prohibit them from offering health insurance to their employees. Those that are continuing to offer health insurance to their employees are doing so by requiring higher employee contributions. As of the present time, many of the uninsured are working poor who opt out of the health insurance plans and many are unemployed. Yet, a portion of the uninsured is healthy and chooses to go without it, a phenomenon known as adverse selection.

As Table 1 demonstrates, United States spends more on healthcare per person than other comparable countries. However, healthcare in the United States is not efficient as measured by the life expectancy at birth.

Table 1: Spending per Person and Life Expectancy at Birth

Country	Spending per Person in International \$, 2009 (PPP*)	Life Expectancy at Birth, 2009
United States	7960	78.2
Canada	4314	80.8
Germany	4219	80.1
France	3969	81.2
United Kingdom	3438	79.9
Japan	3045	83.0

*Purchasing Power Parity: For a market basket of goods and services, the nominal exchange rate at which that basket will cost the same in comparable countries. *Note 1:* Spending per person, PPP was adapted from WHO, 2009 retrieved from http://en.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_%28PPP%29_per_capita *Note 2:* Life expectancy at birth, 2009 as defined by the United Nations Development Program (UNDP) “Number of years a newborn infant could expect to live if prevailing patterns of age-specific mortality rates at the time of birth stay the same throughout the infant’s life.” Source: <http://hdrstats.undp.org/en/indicators/69206.html>

The inefficiency of spending on healthcare and the misallocation of resources prompted the legislation of a system which would cover 100 percent of U.S. population, and at the same time, save the tax payers of a significant amount of waste, both in the government managed Medicaid and Medicare as well as the privately managed health insurance sector. With that in view, the ACA’s primary goal was to make health insurance premiums affordable to all through expanding the public and private insurance coverage and reducing the costs of healthcare for individuals. Starting in 2014, the Law will require all individuals to subscribe to a health insurance plan. The following is a summary of the immediate goals of the ACA:

“The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.” (<https://www.healthcare.gov/glossary/essential-health-benefits/>)

Among many provisions in the ACA, the levels of coverage for services merit attention. The cost of ACA plans varies significantly based on the coverage one chooses. There are four levels of plans: the Bronze, the Silver, the Gold and the Platinum plans. The bronze plan being the least expensive covers 60% of out of pocket health care costs and offers basic coverage. Other plans have progressively higher out of pocket costs, rising 10% for each successive plan: Silver (70%), Gold (80%) and Platinum (90%). In return of progressively higher costs, each plan offers progressively better benefits and networks. The ACA has a built-in redistribution of resources allowing for excise tax on high end users starting in 2018. The taxes thus collected would partially defray the cost of subsidies for poorer subscribers.

HEALTH INSURANCE IN THE UNITED STATES

The health insurance market in the U.S. is oligopolistic in nature; however, it is not the structure of oligopoly market alone that accounts for complexities and profit maximization in the health care sector. As Arrow (1963) noted in his seminal work, medical care is more uncertain than any other product or service. Health care does not fit the free market model because of asymmetric knowledge that exists between the patient and the doctor which Arrow calls uncertainty. Health insurance companies exploit this uncertainty through a variety of means to maximize their profit. The ACA, through its regulatory authority has added a dimension to this market making the health insurance marketplace even less competitive.

Profit Maximization in Oligopoly Health Insurance Market

In 2011, there were 38 health insurance companies in the United States (major medical insurance companies) (http://en.wikipedia.org/wiki/List_of_United_States_insurance_companies). Of the 38 health insurance companies, the market share of the top 5 as reflected by their annual revenues (United Health Group; WellPoint, Inc.; Kaiser Foundation Group; Humana Group; and Aetna Group) was 38%. The market share of other health insurance companies shows a shrinking trend after the top 5. For example, the market share of the next 5 health insurance companies stood at 10.25% in the same year (<http://www.lowcosthealthinsurance.com/who-are-the-top-10-health-insurance-companies-by-market-share/>). It is to be noted that the number of firms in an industry does not indicate the nature of rivalry or the structure of the market. For example, there are approximately 100 carriers in the airline industry, some of which operate in a small region; yet the industry is dominated by three big airlines. Similarly, the health insurance sector is dominated by three to five insurance companies. In 2011, the top 5 health insurance companies served a total of 244 million policy holders (<http://insuranceexchangelist.com/insurance-exchange-lists/>). The Uncertainty Theorem of Arrow aside, major medical insurance has survived as a private good for a long time with the motive of profit maximization similar to other insurance companies like auto and home insurance companies. As explained in Figure 1, pricing of products and services in the health insurance sector follows the oligopolistic model of sticky price fixed at the kink of the demand curve.

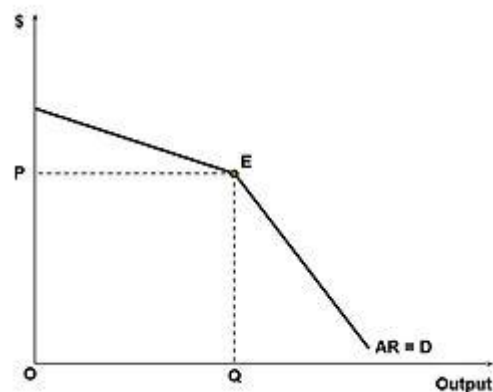


Figure 1: Sticky Price of Healthcare Products

Typically, price of a product in oligopoly market is fixed at the kink and stays at that point for a number of reasons. For an oligopolistic firm, demand is relatively elastic above the kink (above point E), because prices offered by all firms remain unchanged. However, demand is relatively inelastic below the kink implying that the insured would not respond in any significant manner to price changes. Until recently, this model was applicable to health insurance market since it captured the “sticky price” of premiums of different types of health insurance (e.g., PPO, HMO, etc.) It was expected that the ACA would serve to make the health insurance market more competitive through offering a larger number of insurance companies to choose from, and the consumer would benefit from competition in the market place. However, the turn of events since the legislation of the ACA has not resulted in a wider competition among health insurance companies, and the health insurance marketplace remains oligopolistic. Cost of premiums has been negotiated by the State governments with willing providers.

THE HEALTH INSURANCE MARKETPLACE: STATE-MANAGED OLIGOPOLIES

The healthcare system in U.S. is characterized by three distinct health insurance programs. These are: Medicaid, Medicare and private insurance. The Health Insurance Association of America describes Medicaid as a "government insurance program for persons of all ages whose income and resources are insufficient to pay for health care" (http://en.wikipedia.org/wiki/America%27s_Health_Insurance_Plans). Medicare is a federally funded social insurance program for senior citizens who are 65 years of age or older. Private health insurance companies have existed as oligopolies with varying degrees of government regulation from time to time. The Medicare is funded wholly by the federal government while Medicaid is jointly funded by the Federal and State governments but managed by respective States.

As it stands now, the ACA would be implemented through the 38 private insurance companies and would leave the provisions of Medicare intact. In reality, however, three to five health insurance companies dominate the health insurance market, the Medicare and the Medicaid in each State (Table 2). The provisions of ACA list a number of mechanisms to accomplish the goals set by the ACA that include mandates, subsidies and insurance exchanges. The health insurance marketplace consists of three types of health insurance exchanges: an insurance exchange run by a State where health insurance coverage is available through the State's official website; an insurance exchange partnership run by a State and the Federal government; and an insurance exchange run only by the federal government where coverage is available through the US Government's website (<http://insuranceexchangelist.com/insurance-exchange-lists/>). The following is a break-down of the three types of insurance exchanges chosen by the 50 states and the District of Columbia:

- Federal 26
- State 18
- Partnership 7

The key provision of the ACA calls for providing affordable health insurance through the State insurance exchanges. As Table 2 shows, the commercial health insurance market is highly concentrated across the country. The Table divides the 50 states and Washington, D.C. into six regions: Mid-Atlantic, New England, Southwest, Midwest, South, and West. In each of the six regions, three health insurance companies occupy a large share of the market. It is interesting to note, in the more populous regions, New England and West, "Big Three" insurance companies occupy 57 percent and 52 percent of the market share respectively.

This finding is not surprising since the essence of oligopoly business is capturing market niche. Bigger airlines, for example, have come to some kind of tacit collusion in operating territories known as hubs. Bigger health insurance companies, taking advantage of government regulations and with significant resource advantage are able to bundle their products and services in more populous states than their smaller counterparts.

At a time when ACA is being implemented, the State run Medicaid program and the Federal Medicare program will both be in place. The federal government is gradually integrating the benefits of Medicaid with those of the ACA. In a recent public announcement, the Department of Health and Human Services has initiated the process for public hearing for State administration of basic health programs; eligibility and enrollment in standard health plans; essential health benefits in standard health plans; performance standards for basic health programs; premium and cost sharing for basic health programs; Federal funding process; trust fund and financial integrity. The summary of the announcement states:

"This proposed rule would establish the Basic Health Program, as required by section 1331 of the Affordable Care Act. The Basic Health Program provides states the flexibility to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the state's Affordable Insurance Exchange (Exchange, also called a Health Insurance Marketplace). The Basic Health Program would complement and coordinate with enrollment in a QHP through the Exchange, as well as with enrollment in Medicaid and the Children's Health Insurance Program (CHIP). This proposed rule sets forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. Additionally, this rule would amend other rules issued by the Secretary

of the Department of Health and Human Services (Secretary) in order to clarify the applicability of those rules to the Basic Health Program.” (<https://www.federalregister.gov/articles/2013/09/25/2013-23292/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in>)

Table 2: Market Share of Top 3 Health Insurance Companies in Census Regions

Mid Atlantic Market		Market Share	Midwest Market		Market Share
Commercial	UnitedHealth Grp	17%	Commercial	HCSC Grp	11%
	Wellpoint Inc Grp	12%		Wellpoint Inc Grp	11%
	Aetna	10%		BCBS of MI Grp	10%
Medicare	Highmark Inc	15%	Medicare	UnitedHealth Grp	21%
	Independence Blue Cross	13%		Wellpoint Inc Grp	16%
	HIP Ins Grp	10%		Humana Inc	9%
Medicaid	UnitedHealth Grp	17%	Medicaid	Centene Corp Grp	15%
	Independence Blue Cross	11%		CareSource Grp	15%
	UPMC Health System	11%		Coventry Corp Grp	7%
New England		Market Share	South		Market Share
Commercial	BCBS of MA Grp	27%	Commercial	Wellpoint Inc Grp	17%
	Wellpoint Inc Grp	21%		BCBS of FL Grp	10%
	Harvard Pilgrim Grp	9%		UnitedHealth Grp	7%
Medicare	Tufts Assoc Health Plans	22%	Medicare	Humana Inc	35%
	BCBS of RI	17%		UnitedHealth Grp	16%
	Harvard Pilgrim Grp	15%		WellCare Grp	6%
Medicaid	Wellpoint Inc Grp	28%	Medicaid	WellCare Grp	24%
	Neighborhood Hlth Plan Inc	21%		Wellpoint Inc Grp	13%
	Health Net Inc Grp	18%		Amerigroup	11%
Southwest		Market Share	West		Market Share
Commercial	HCSC Grp	26%	Commercial	Kaiser Foundation	26%
	Aetna	11%		Wellpoint Inc Grp	15%
	Humana Inc	9%		Blue Shield of CA Grp	11%
Medicare	UnitedHealth Grp	46%	Medicare	Kaiser Foundation	36%
	Humana Inc	7%		UnitedHealth Grp	22%
	Lovelace Grp	6%		Wellpoint Inc Grp	11%
Medicaid	Amerigroup	33%	Medicaid	Wellpoint Inc Grp	20%
	Centene Corp Grp	13%		Health Net Inc Grp	15%
	Presbyterian Hlthcare	11%		Local Health for LA Cnty	14%

The above proposal, delayed due to the shut-down of the federal government and yet to be formally announced, provides a direction of the ACA in bringing the Medicaid under the same umbrella. However, implementation of the ACA would still continue under State management as State funded oligopolies. While the regulatory aspect of the Law would eliminate adverse selection, lack of competition in an oligopoly market structure would not lower the cost of health insurance significantly.

SUGGESTIONS FOR REFORM OF THE HEALTH INSURANCE MARKETPLACE

As analyzed in the preceding sections, the newly created Health Insurance Exchange continues to operate as State managed oligopolies. The cost of health insurance is “administered” by two parties, the private insurance companies and the respective State, a phenomenon unique to oligopoly market. In order for the marketplace to be competitive, consumers should be able to shop for health insurance from more than a limited number of health insurance companies (three to five) in each State. At the present time, individuals have the option of subscribing to multiple coverage through Medicare and Health Insurance Exchange, and perhaps through Medicaid and Health Insurance Exchange. In either or both cases, over-use of one or both plans may lead to moral hazard arising from perceived reduction in price of health insurance coverage.

Given that U.S. Healthcare System is largely similar to the German system, the author proposes reforms of the Health Insurance Exchange in line with the German system, a brief description of which is provided below (adapted from: <http://www.aicgs.org/issue/structure-of-the-german-health-care-system/>). Dating back to Otto Von Bismarck's social legislation in 1883, Germany has the world's oldest national social health insurance system. Specifically, German *Health Insurance Bill of 1883*, *Accident Insurance Bill of 1884*, and *Old Age and Disability Insurance Bill of 1889* have many similarities to the U.S. *Social Security Act of 1935* and *Occupational Safety and Health Act (OSHA) of 1970*. In Germany, health insurance coverage is universal. Mandatory health insurance is provided by approximately 1,100 public or private sickness funds known as *Krankenkassen*. In the German system, about 85 percent of residents purchase heavily regulated, non-profit insurance referred to as *Gesetzliche Krankenversicherung* (Statutory Health Insurance, GKV), approximately 10 percent buy private insurance, and the remaining 5 percent fall into other insurance schemes. Standard insurance is funded by a combination of employee contributions, employer contributions and government subsidies on a scale determined by income level. Higher income workers sometimes choose to pay a tax and opt out of the standard plan, in favor of 'private' insurance. The latter's premiums are not linked to income level but instead to health status. Historically, the level of provider reimbursement for specific services is determined through negotiations between regional physician's associations and sickness funds.

Other features of the German Healthcare System include:

- All Germans earning under a yearly adjusted rate of approximately €50,000 per year are required to purchase GKV from a *Krankenkasse*.
 - Individuals pay for insurance based on their income, paying 8.2 percent of their gross wages up to €44,550 (in 2011) while their employer contributes an additional 7.3 percent of their gross wages.
- *Krankenkassen* are non-profit insurers who are legally required to accept all applicants and are permitted to sell health insurance (GKV).
 - Traditionally, *Krankenkassen* were associated with industries, meaning that individuals would purchase GKV through the *Krankenkasse* in their industry. Today, individuals have greater freedom to choose between *Krankenkassen*, though they must still buy through their employer.
- GKV includes complete coverage of most health needs, with the exception of long-term care.
 - GKV does include long-term care, but benefits are usually insufficient and most choose to supplement GKV with private insurance.
 - A council of representatives from the health care industry, the *Gemeinsame Bundesausschuss*, has legal authority to determine what services must be included in GKV.
- Providers negotiate with *Krankenkassen* on a regional basis to determine eligibility.

Civil servants and the self-employed who are not covered by the employer-based GKV system, purchase private insurance. In addition, individuals earning above approximately €50,000 per year are permitted to opt out of purchasing GKV and purchase private health insurance instead. Private insurance is also heavily regulated, but is generally more flexible and more expensive than GKV.

Both the U.S. and German healthcare systems are designed to run through the health insurance market; however, the above brief description of German healthcare system is in sharp contrast to the U.S. system. The German system is much older than the U.S. system and has survived more than 125 years witnessing two world wars

and many geo-political scenarios because it was embedded culturally into its citizens as a basic right. The most significant part of German health insurance is the Krankenkassen or sickness funds which compete among themselves for market share. These are private entities performing without profit motives. Premium for these funds are deducted from an individual's paycheck towards the insurance where approximately an equal amount is contributed by the individual's employer. In a nutshell, the Krankenkassen are far exceed in number than the U.S. Health Insurance Exchange forming a monopolistically competitive market and each striving to increase its market share.

Following the German Healthcare model, the following suggestions for reform of the ACA emerge:

1. Because the U.S. Health Insurance Exchange is oligopolistic in each State, premium paid by subscribers is higher than it would be in a monopolistically competitive market. The German Krankenkassen or Sickness Funds numbering over 1100 provide an ideal model for the Health Insurance marketplace. Following the German model, each State should require all insurance companies to compete for subscribers. This will gradually move the Health Insurance Exchange from oligopoly structure to monopolistically competitive status resulting in lower premiums to subscribers.
2. At the present time, 3 to 5 health insurance companies occupy more than 30 percent market share of private insurance, Medicare and Medicaid. The government should devise ways and means to ensure that the dominance of the big health insurance companies gradually vanish allowing for enhanced competition among them.
3. The government is in the process of integrating the Medicaid under the ACA umbrella. Once the Health Insurance Exchange becomes fully operational, the Medicare should also be integrated with the ACA. This will create one fund similar to the Krankenkassen or the Sickness Fund of Germany which will eliminate wastes in the system. The advantage of getting rid of the Medicare will be cost-saving by the subscribers which can be passed on to a single Health Insurance Exchange. This will also reduce the tax burden of the working population where contribution to Medicare is mandatory.

SUMMARY AND CONCLUSIONS

As an integral part of the ACA, the Health Insurance Exchange became operational in October 2013. At the present time, there are 38 health insurance companies with 3 to 5 companies dominating in each State and operating like State managed oligopolies. Because of the oligopolistic structure of the health insurance market, premiums paid by private subscribers continue to be high. Alongside the private health insurance companies, two other forms of government funded health insurance namely, Medicaid and Medicare coexist for two distinct groups of population. The Medicare and the Medicaid are also managed by the State and the market structure for these government funded insurance is also oligopolistic. The ACA introduced four different types of health insurance coverage, namely Bronze, Silver, Gold and Platinum coverage. Even if the Medicaid insurance is integrated with the ACA, the high end insurance plans will leave room for moral hazard. Additionally, when the ACA becomes fully operational with universal coverage, there may not be a need for the Federally funded Medicare program. The existence of three health insurance programs, namely Health Insurance Exchanges of private insurance companies, Medicaid and Medicare, all with oligopolistic structure calls for a reform of the system. The paper briefly reviewed the German healthcare system with particular reference to Krankenkassen or Sickness Funds and argued in favor of eliminating State managed oligopolies through government regulation, and thus allowing the Health Insurance Exchange to move from the oligopoly to the monopolistically competitive market structure.

AUTHOR INFORMATION

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REFERENCES

1. ----- (1966).Some major policy decisions facing the United States in the financing and organization of health care. *Journal of Urban Health. Bull. NY Academy of Medicine*. December 1966; 42(12): 1072–1088.
2. Angel, Marcia (2004). *The Truth About the Drug Companies: How They Deceive Us and What to Do About It*. New York: The Random House.
3. Arrow, Kenneth J. (1963). Uncertainty and the Welfare Economics of Medical Care. *American Economic Review*. Volume 53, Issue 5 (Dec., 1963). 941-973.
4. Brownlee, Shannon (2007). *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer*. New York: Bloomsbury.
5. Burns, Eveline M. (1956). *Social Security and Public Policy*. New York: McGraw-Hill.
6. Ceullar, Aloson Evans and Wiener, Joshua M. (2000). Can Social Insurance For Long Term Care Work? The Experience of Germany. *Health Affairs*. Volume 19, 3. May/June 2000. 8.
7. Fuchs, VR (2002). What’s Ahead for Health Insurance in the United States? *New England Journal of Medicine*. June 2002. 1822-1824.
8. Gratzner, David (2006). *The Cure: How Capitalism Can Save American Health Care*. New York: Encounter Books.
9. Halvorson, George C. (2009). *Health Care Will Not Reform Itself: A User’s Guide to Refocusing and Reforming American Health Care*. New York: CRC Press.
10. Hiltz, Philip J. (2003). *Protecting America’s Health: The FDA, Business and One Hundred Years of Regulation*. Chapel Hill and London: The University of North Carolina Press.
11. Himmelstein, David and Woolhandler, Steffie. (2001). *Bleeding the Patient: The Consequences of Corporate Healthcare*. Common Courage Press. Monroe, ME: 2001.
12. Himmelstein, David; Woolhandler, Steffie; Hellander, Ida; Wolfe, Sydney. (1999). Quality of Care in Investor-Owned vs Not-for-Profit HMOs. *Journal of American Medical Association*. Volume 282, No. 2. 159-163.
13. Jonas, S. (1969). Health Services for All: Is Health Insurance the Answer: Commentary. *American Journal of public Health*. Vol. 59, No. Suppl_1. January 1969. 23-24.
14. Moynihan, Ray and Cassels, Alan. (2005). *Selling Sickness: How the World’s Biggest Pharmaceutical Companies are Turning us into Patients*. New York: nation’s Books.
15. Reid, T.R. (2009). *The Healing of America; A Global Quest for Better, Cheaper and Fairer Health Care*. New York: The Penguin Press.
16. Welch, Gilbert; Schwartz, Lisa M. and Woloshin, V. (2011). *Over-Diagnosed – Making People Sick in the Pursuit of Health*. Boston: Beacon Press.
17. Wilper, Andrew P.; Woolhandler, Steffie; Lasser, Karen E.; McCormick, Danny; Bor, David H and Himmelstein David. (2009). Health Insurance and Mortality in U.S. Adults. *American Journal of Public Health*. Volume 99, December 2009: Pages 2289-2295.

INTERNET REFERENCES

1. <http://www.aicgs.org/issue/structure-of-the-german-health-care-system/>
2. http://www.census.gov/newsroom/releases/archives/income_wealth/cb13-165.html
3. http://en.wikipedia.org/wiki/America%27s_Health_Insurance_Plans
4. http://en.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_%28PPP%29_per_capita
5. http://en.wikipedia.org/wiki/List_of_United_States_insurance_companies
6. <https://www.federalregister.gov/articles/2013/09/25/2013-23292/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in>
7. <http://hdrstats.undp.org/en/indicators/69206.html>
8. <https://www.healthcare.gov/glossary/essential-health-benefits/>
9. <http://insuranceexchangelist.com/insurance-exchange-lists/>
10. <http://www.lowcosthealthinsurance.com/who-are-the-top-10-health-insurance-companies-by-market-share/>
11. <http://www.reuters.com/article/2009/09/17/us-usa-healthcare-deaths-idUSTRE58G6W520090917>