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Healing a Patchwork of Health Problems

Insurers Are Not the Bad Guys

by John Goodman, PhD

In the aftermath of the senseless murder of the CEO of United-Healthcare, responsible commentators were quick to condemn the act.

"Murder is bad, and so are murderers," wrote the liberal economist Paul Krugman. "Neither should be celebrated." But then Krugman went on to offer an admittedly "somewhat … caricatured" view of U.S. health care: "It's a system in which taxpayers bear the cost of major medical care, but this taxpayer money flows through private companies that take a cut, spend a lot on administration, and do their best to deny care to people who need it."

What service do private insurers provide in return for the fees they collect? Americans, Krugman wrote, "may not realize the extent to which they are exposing themselves to the delay-and-deny strategy private insurers often use to avoid paying for care."

Krugman has been an advocate of single-payer health insurance, using Canada as a model to be emulated. In Canada, there are no health insurance companies. When Canadians get health care, the cost is paid by the government.

If Canadians can get by without health insurance companies, could something like that work in the United States? Not in a way people would find desirable.

There are three problems with the doctor-patient relationship in all developed countries — regardless of the way the payment system is organized.

First, when a third party is paying the bill, neither the doctor nor the patient has any incentive to apply the kind of cost/benefit analysis that is normal in the purchase of any other good or service. In considering whether to obtain an expensive test (an MRI scan, e.g.), the incentive is to consider only the benefit. Since cost is irrelevant to the patient, a tiny benefit — no matter what the cost — is viewed as desirable.

Second, in a fee-for-service arrangement, the more services doctors perform, the higher their incomes. So, just as patients have an incentive to over-consume, doctors have an incentive to over-provide.

Third, there is malpractice liability, which is especially a problem in the U.S. A doctor who orders an unnecessary MRI scan faces no real penalty. But no matter how improbable, there is always a chance that a scan not ordered will fail to detect a problem that grows worse over time. Our legal system, therefore, provides incentives for too many tests and too many procedures, compared to a system in which costs would have to be justified by comparable benefits.

These three perverse incentives make medical care unreasonably expensive with higher premiums and higher taxes.

Canada Rations Care

Canada checks these incentives by limiting resources. The typical Canadian general practitioner, for example, does not have radiology equipment and must send patients to a hospital for simple x-rays. The hospitals, in turn, operate under global budgets that limit spending, no matter what the level of demand.

Canada ranks 25th of 29 countries on the number of MRI scanners per person. As a result, the wait for a scan is almost three months, and the wait until final treatment is more than six months. The government has decided to prevent overuse of MRI scanners by severely restricting the number of scanners that are available.

Canada's system of limiting health care resources and forcing doctors to ration care has many undesirable characteristics. The system favors high-income over low-income patients. It favors white patients over racial minorities. It favors city dwellers over rural residents. It favors the politically connected over those without connections.

Arguably, there is more inequali-

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ty in access to health care in Canada than there is in the United States.

Does rationing care force doctors to be more efficient? Studies by the RAND Corporation found that this isn't so. In Canada and Britain, scholars found just as much unnecessary care (as a percent of the total) as they found in the United States.

Fraud is an acute problem in government-administered programs. In Medicare and Medicaid fraud is estimated to consume at least $100 billion a year.

Hospital upcoding (claiming a higher level of patient severity in order to obtain a higher insurance payment) is another problem. One study estimates that increased upcoding (relative to a decade earlier) was associated with $14.6 billion in hospital payments.

Although doctors are the biggest critics of claim denials, hospitals are by far a bigger problem.

Suppose a patient's condition is stabilized in an ER. Then the medically correct procedure is usually to send the patient home and let further care be outpatient. Yet some hospitals will keep the patient for a night or two and try to bill an insurer for that cost.

Suppose a patient's condition warrants keeping the patient in an "observation bed" for a night or two. Some hospitals will treat the patient as a full admission instead and try to bill the insurer at a much higher rate.

These are just two of hundreds of ways some hospitals try to add unnecessary costs to our health care system. When insurers deny these claims they are performing a check on price gouging.

The Role of Preauthorization

An important tool private insurers use to avoid unnecessary spending and inappropriate care is to require preauthorization for a particular drug, therapy, or procedure. Doctors tend to regard these procedures as burdensome and irksome. Yet only 7.4% of requests by patients in Medicare Advantage and Medicaid managed care plans are denied. Moreover, in the vast majority of appeals (83.2%), the initial denials are overturned.

Doctors are using AI to file their appeals, which greatly reduces the time to file and increases the success rate.

Overall, our health insurance system can be improved, and scholars associated with the Goodman Institute have proposed many ways to do that. But we cannot have a system that works well without companies that perform the functions health insurers are performing today.

The public seems to understand this. Despite occasional complaints, more than two-thirds of Americans rate their health insurance as "good' or "excellent." And that holds for all kinds of insurance: employer plans, (Obamacare) marketplace plans, Medicare, and even Medicaid.

Even among people who say they are not in good health (and who, presumably, need medical care), a substantial majority give positive ratings to their health plans. Only a tiny percent rate their insurance as "poor."

TRANSPARENCY AND COMPETITION ARE NEEDED

by Lawrence Wilson, The Epoch Times

American health insurance seems to frustrate everyone. Patients complain that it's expensive and complicated. Providers say it buries them in paperwork and can negatively affect patient care.

Fully 70% of the country thinks American health care has major problems or is in a state of crisis. Consumer satisfaction is at a 24-year low. Yet identifying a villain here is no simple matter.

The American health payment system is a ramshackle structure comprising public and private insurance plans offered by a host of providers across multiple states. Over many decades, the system has been layered with more legislative patches than the roof on your grandfather's barn.

Despite the good intentions of lawmakers, regulators, countless health care workers, and insurance companies, health insurance remains expensive and confusing for the 92% of Americans who have it and for the 8% who do not.

Despite its problems, many experts believe the health payment system can be improved. Some want to level the ground and build a new system from scratch. Others advocate refinements to make health insurance less expensive and more transparent. Any solution will require cooperation among a host of key players, including insurance companies, health care providers, state governments, and that most unpredictable of all institutions, the United States Congress.

Here's an overview of the symptoms affecting the health care payment industry, some root causes, and cures suggested by industry analysts.

The Payers

Employer-sponsored insurance is the most common way Americans get health care coverage. This includes self-funded plans, in which the employer acts as the insurer, and commercial health insurance purchased by a company for its employees. More than 178 million people had ESI in 2023, according to the U.S. Census Bureau.

Self-purchased health insurance

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is obtained by individuals directly from an insurance company, sometimes with the aid of an insurance agent or through the Affordable Care Act Marketplace. The Marketplace offers premium discounts in the form of tax credits based on the buyer's income. Nearly 34 million people bought their own health insurance in 2023. Of those, about 13.3 million used the Marketplace.

Medicare is a federal entitlement program that provides health insurance for Americans age 65 and above, people with a disability, and those having end-stage renal disease or ALS. Medicare covered about 63 million people in 2023.

Medicaid is a government program that provides health insurance and other benefits to low-income Americans. Medicaid is funded by both the federal government and the states. It is administered by the states within guidelines provided by the federal government. Coverage can vary from state to state. Medicaid covered about 63 million people in 2023.

Also in 2023, about 9 million people were covered by TRICARE, a program for U.S. servicemembers, their dependents, and retirees administered by the U.S. Department of Defense. Another 3 million people were covered by the Veterans Administration and related programs.

About 26 million people had no health insurance in 2023.

Symptoms

The most frequent complaint about health insurance is the cost. About half of Marketplace (55%) and ESI users (46%) gave their health insurance a negative rating based on its premiums in a 2023 survey by KFF. That's roughly double the dissatisfaction rate for Medicare (27%) and Medicaid beneficiaries (10%).

The cost of ESI for a hypothetical family of four in 2024 was $32,066, according to the actuarial firm Milliman. Of that total, about 58% would typically be paid by the employer.

"The growing refrain within small and mid-sized businesses is that providing health insurance for their employees is becoming unsustainable," said Orriel Richardson of Morgan Health.

Another pain point with health insurance is the complexity of the plans. Consumers say this makes their coverage difficult to use and often seems unfair. Providers say the requirements are burdensome to them and make it more difficult to provide good health care.

Nearly two-thirds of Americans, 65%, said they don't think health insurance providers are transparent about their coverage, according to a 2024 poll conducted by physician network MDVIP and Ipsos.

A 2023 KFF report showed that 58%, had trouble using their insurance within the preceding year. Denied claims, provider network issues and preauthorization were commonly cited problems. About half of those who experienced problems were unable to find a satisfactory resolution.

Insurance companies generally do not publish their claim denial rates, though the data analysis firm Experian Health reported in 2024 based on provider surveys that claim denials are increasing. Thirty-eight percent of respondents said at least 10% of their claims were denied by the insurer.

Providers are frustrated too. The administrative demands required by insurance companies are a particular pain point. Experian found that 65% of providers said meeting the insurers' claim-submission requirements is harder now than before the pandemic.

More than 80% of nurses said the administrative demands imposed by insurance companies delay patient care, and about 75% said insurance policies reduce the quality of care according to a 2023 survey by the American Hospital Association. More than 80% of physicians said insurance policies hamper their ability to practice medicine.

Causes

The health insurance industry did not develop purely as a market response to a need as many other businesses did. It was patched together over a hundred years or so through a combination of business and government interventions.

"We are working with a healthcare system that was never truly designed for the purpose of making people healthier and having them live their optimal lives," Richardson said.

ESI was started in the early 1900s by employers looking to ensure a reliable workforce. The Affordable Care Act now makes ESI mandatory for many employers. Medicare and Medicaid were created in 1965 to provide health coverage for uninsured Americans and coverage has widened over time.

The many silos and layers of legislation make for a complex system that is difficult for Congress, let alone consumers, to understand.

Because of consolidation, private health insurance has become more concentrated among fewer, larger insurers and care providers. The six largest health insurers in the country accounted for nearly 30% of all U.S. health care spending in 2023.

"As markets become more concentrated, they may also become less competitive. This may result in higher premiums, decreased access to affordable health insurance, and fewer options for consumers," John Dicken, director of health care at the U.S. Government Accountability Office.

A state's insurance market is concentrated when fewer than four insurance companies control 80% or more of the market share. Some 95%

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of U.S. health insurance markets in metropolitan areas were highly concentrated in 2022, according to the American Medical Association.

Insurers have also consolidated vertically, meaning that some have acquired the health providers they pay for services, which makes it harder to track how much money is actually spent on health care.

That number, known as the medical loss ratio (MLR), is a key metric in both public and private health insurance. When the MLR dips below a certain threshold — typically 80 or 85% depending on the type of insurance — the company is required to rebate premiums to the consumer.

"Insurers that own providers can manipulate the MLR system by inflating the prices they pay to their own providers and increasing the amount categorized as medical spending," Natasha Murphy, director of health policy for the Center for American Progress, a progressive policy institute, wrote in a December 2024 report.

Perhaps the most sobering root problem affecting the cost of health insurance is that Americans, on the whole, are sicker than they used to be.

Millennials are significantly less healthy than their Generation X predecessors, according to a 2019 study conducted by the Blue Cross Blue Shield Association.

The study found that about one-third of Millennials suffer from conditions that can affect quality of life and reduce life expectancy. Millennials had higher rates of cardiovascular disease and endocrine conditions such as diabetes.

It costs more to provide health care to a larger, sicker population.

Prescriptions for Change

Ideas for improving the health payment system come in two types: reboots and refinements.

Reboots include ideas for sweeping change, such as the Medicare for All proposal advocated by Sen. Bernie Sanders (I-VT). The proposal would create a national health insurance program to provide comprehensive health care for all U.S. residents.

Liran Einav of Stanford University and Amy Finkelstein of the Massachusetts Institute of Technology have proposed a narrower version of universal health coverage. Under their proposal, all Americans would automatically be enrolled in basic health coverage at no cost to the enrollee. People could supplement that coverage with self-paid private insurance if they chose to.

Unlike Medicare and Medicaid, which have no cost cap, the Einav-Finkelstein plan would set an overall limit on taxpayer spending for health care.

Other ideas for improving health insurance would maintain the basic framework of public and private insurance systems but refine it to reduce cost and improve transparency. Several of these ideas focus on making health insurance more competitive.

Bruce Ratner, a former head of the Consumer Protection Division for New York City, advocates requiring health insurers to publish their denial rates. That would likely require an act of Congress and would lower prices according to Ratner.

"That way we choose our company based on denial rates, and that makes the companies work very hard to be competitive," Ratner said.

Mark Bertolini, CEO of Oscar Health, advocates eliminating ESI to improve competition. Oscar Health is an insurance company that uses data to match individuals with tailored health coverage.

Small and mid-sized companies are hit hardest, seeing double-digit annual rate increases for their health plans, because they must buy more expensive plans to meet the needs of all employees. Giving employees a cash contribution for health insurance rather than purchasing a plan for them would allow each person to select the insurance that fits their needs, Bertolini said.

Competition could be increased also by eliminating anti-competitive contracting practices used by some large insurance companies and health care providers. Those practices include clauses that force a provider to charge an insurer lower rates than those offered to other companies, gag clauses that prevent either the payer or provider from disclosing price information to patients, and exclusivity clauses that make the contracted provider the only in-network option.

"Together with employers, governments, and others who pay for care, we need to improve how we explain what insurance covers and how decisions are made," he said. "Behind each decision lies a comprehensive and continually updated body of clinical evidence focused on achieving the best health outcomes and ensuring patient safety."

Acknowledging the growing urgency to improve health insurance, Richardson likens the system to a house with several layers of shingles on the roof.

"We have a house that is sustainable enough, but instead of removing the shingles to repair the roof we keep cobbling new shingles onto it," she said. "The very house itself is going to collapse under this patchwork of things we keep doing."

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