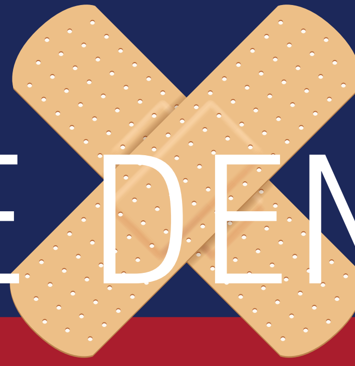

COVERAGE DENIED

ISSUE BRIEF PART ONE

The Flawed Health Insurance Model Inflates Costs, Decreases Quality, and Reduces Patient Health Outcomes

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October 2021

Executive Summary

- Health insurance is failing to serve its primary function of mitigating the financial risks associated with expensive medical care.
- Instead of providing patients with effective risk-management services, the health insurance industry is implementing policies that restrict access to care or inappropriately transfer costs to patients, often long after the service has been provided.
- Access barriers and improper cost-shifting contribute to the problems of bankrupting medical debt and declining health outcomes.

Introduction

No matter how many times a bad system is tweaked it will never produce the desired results, and the current U.S. health insurance system is a bad system. By design, though not intention, it creates adverse incentives and imposes inefficient constraints that thwart beneficial competition, incentivize industry practices that threaten patient health outcomes, and fail to adequately mitigate the financial risks associated with adverse health care events. Consequently, improving patient outcomes and addressing the health care affordability problem requires fundamental reforms that address these obstructions.

In the *Coverage Denied* series, the Center for Medical Economics and Innovation at the Pacific Research Institute presents a multi-part research program with the goals of defining the adverse incentives and inefficient constraints of the current health insurance industry, connecting these adverse incentives to unwanted outcomes such as increased financial risks for patients and decreased health care quality, and recommending reforms that will address these problems. These topics will be explored through a series of short issue briefs that tightly focus on one aspect of the problem. Taken as a completed series, the papers will provide a comprehensive assessment of the problem and proposed policy reforms that address them. This report is the first issue brief in the series.

This first issue brief in the series will demonstrate the systemic flaws of health insurance in the U.S. by defining the societal purpose health insurance is supposed to serve and then documenting how the current system is failing to adequately serve this purpose.

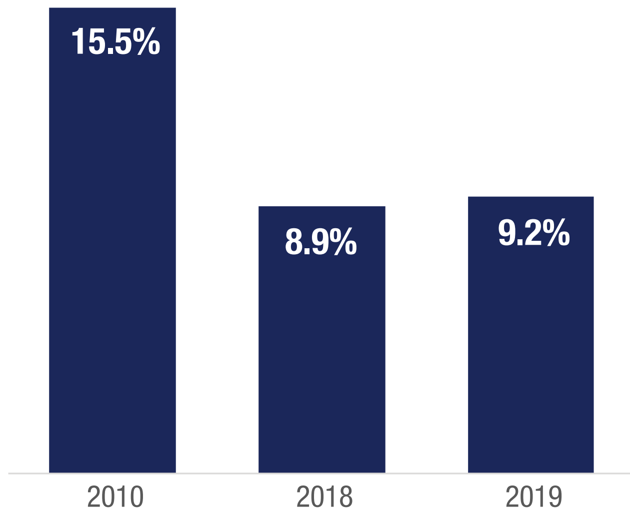
Health Insurance Versus Health Care

The current health insurance debates are often plagued by a fundamental flaw because they confuse health insurance with health care, but health insurance services are distinct from health care services. Health care refers to the actual prevention or treatment of illnesses and injuries, and typically refers to the cases when these services are provided by certified health professionals (a topic for a different analysis). Health insurance, on the other hand, is a financial service. The purpose of health insurance is to mitigate the potential financial risks that can be incurred if a person requires expensive medical services.

While distinct, health insurance and health care are necessarily inter-related. According to the Kaiser Family Foundation, "people without insurance coverage have worse access to care than people who are insured. Three in ten uninsured adults in 2019 went without needed medical care due to cost."[1] Despite being inter-related, the recent coverage and health quality data demonstrate that expanding poorly devised health insurance coverage does not improve health care outcomes.

Starting with the coverage data, Figure 1 presents the U.S. Census data on health insurance coverage for three years: 2010 [which is the year the Affordable Care Act (ACA or Obamacare) was passed], 2018, and 2019 (which are the latest data available).[2] As Figure 1 demonstrates, while slightly fewer people have insurance coverage in 2019 compared to 2018, the percentage of uninsured people has declined by over 40 percent since 2010 – from 15.5 percent of the population in 2010 to 9.2 percent of the population in 2019. However, it is equally true that key measures of health care quality have been declining even as the share of the population without insurance has been rising since the ACA was passed.

FIGURE 1
PERCENTAGE OF AMERICANS WITHOUT HEALTH INSURANCE COVERAGE
2010, 2018, AND 2019



Source: U.S. Census

A large share of the increased insurance coverage has occurred through the expansion of Medicaid,[3] but the expansion of Medicaid coverage has not led to an unequivocal improvement in health care quality. A pivotal Medicaid study out of Oregon found that while the expansion of Medicaid increased the use of preventive services and diminished financial hardship and depression, it "had no statistically significant effects on physical health measures.[4] Specifically, Medicaid did not have a statistically significant effect on measured blood pressure, cholesterol, or glycated hemoglobin (a measure of diabetes)."[5]

Perhaps worse, over the same time there have been marked declines in several health care quality metrics. For instance, "the mortality rate for deaths amenable to healthcare in the U.S.", which had been declining for more than two decades, stopped declining starting in 2013.[6] By 2017, the total life years lost that results from medical conditions for which there are recognized health care interventions expected to prevent death was 12,282 per 100,000 population or 4.1 percent higher than the mortality rate in 2013 (11,794).[7] In fact, the rate of decline appreciably changed in 2010, which is the year the ACA passed.

A similar trend has occurred with respect to the burden of disease. According to the Health System Tracker, "the U.S. disease burden rate dropped by 14 percent from 1990 to 2013, while similarly wealthy countries saw an average decrease of 22 percent. Since then, disease burden has continued to decrease in comparable countries but has increased by approximately three percent in the U.S."[8] Consistent with these declining health outcomes, the percentage of adults who reported "that their general health was fair or poor" increased from 18.1 percent in 2011 to 18.6 percent in 2017.[9]

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The onset of COVID-19 has only worsened these trends. As the Health System Tracker 2020 noted, "in the past few years, disease burden has worsened in the U.S. (driven by substance use disorders and an uptick in injuries) while continuing to improve in similar countries. Although disease burden is likely to increase in all countries due to the pandemic, length of life may decrease more in the U.S. than in peer countries."[10] While there are many complicating factors driving down health outcomes in the U.S., given the failure of health insurance to fulfill its primary function, it is unsurprising that the expansion of health insurance coverage was of limited value toward improving health care quality.

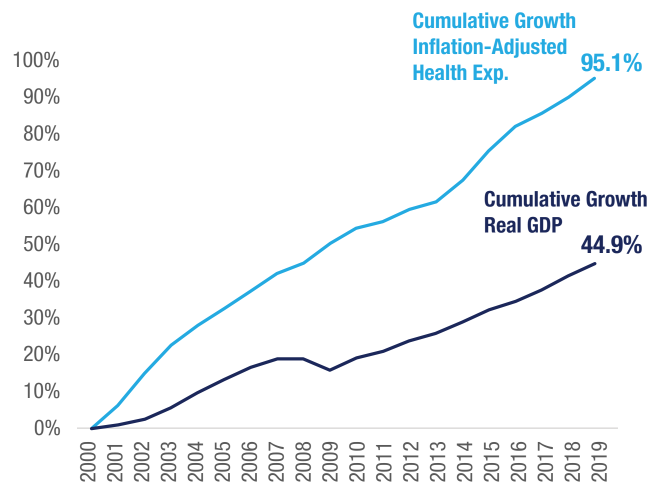
Health Insurance Focus Has Become Expenditure Controls Not Financial Risk Management

Expanding coverage does not improve overall systemic quality because health insurance has become a means to control health expenditures rather than a means to manage financial risks. Exemplifying the current logic guiding insurance policies, the *Merck Manual* suggests that,

> health care costs can be controlled or decreased only by using strategies that decrease the following:
>
> - How much people use health care services
> - How much providers are reimbursed for services
> - How much the overhead of running a health care business is (overhead excludes the costs of providing health care).[11]

These options are based on a false premise – productivity growth can improve quality and decrease costs in health care just as it has in other parts of the economy (e.g., technology). Nevertheless, there are sound reasons for health insurers to focus on expenditure control. After all, total inflation adjusted health consumption expenditures were 95.1 percent higher in 2019 compared to 2000 while the size of the economy is only 44.9 percent larger, see Figure 2.

FIGURE 2
CUMULATIVE GROWTH IN INFLATION-ADJUSTED NATIONAL HEALTH CONSUMPTION EXPENDITURES COMPARED TO CUMULATIVE GROWTH IN INFLATION-ADJUSTED GROSS DOMESTIC PRODUCT (GDP)



Source: Author calculations based on data from CMS and BEA

These rising costs are reflected in high premium costs, which "for employer-sponsored family health coverage reach[ed] $21,342 this year [2020], up 4% from last year, with workers on average paying $5,588 toward the cost of their coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,644 for single coverage."[12] It was not just employers directly paying these costs either as workers' share of the premium costs were more than three times higher in 2020 compared to 2000.

In response to the rising costs relative to economic growth, the health insurance industry is attempting to rein in expenditures via policies that make it more difficult for patients to receive their prescribed care or denies prescribed coverage all together. Often, these actions leave patients exposed to the large financial risks from required medical services, which ironically means that the health insurance industry's focus on controlling costs has become an obstruction for achieving their primary purpose.

Health Insurance Fails to Adequately Mitigate Financial Risks

There is growing evidence that health insurers are failing their primary function of mitigating the financial risks associated with expensive medical services.

One explanation for this failure to mitigate financial risks is the widespread use of deductibles, coinsurance, and copayments. As the Kaiser Family Foundation survey found, "65 percent of covered workers have coinsurance and 13 percent have a copayment that apply to inpatient hospital admissions. Lower percentages of workers have per day (per diem) payments (7 percent), a separate hospital deductible (1 percent), or both a copayment and coinsurance (8 percent), while [only] 16 percent have no additional cost sharing for hospital admissions after any general annual deductible has been met."[13]

As a result of being exposed to excessive costs, financial bankruptcies due to medical debt remain a crippling problem for too many families.

Large deductibles, copayments, and coinsurance each expose patients to large financial costs if they need expensive health care services. For instance, a study in the *American Journal of Preventive Medicine* found that the average (mean) out-of-pocket spending for 14,278 influenza hospitalizations was $987.[14] In three percent of the cases, the out-of-pocket costs exceeded $2,500.[15]

As a result of being exposed to excessive costs, financial bankruptcies due to medical debt remain a crippling problem for too many families. Quantifying these costs, a study by the Stanford Institute for Economic Policy Research (SIEPR), found that the U.S. has an $81 billion medical debt crisis that impacts an unacceptably large portion of the population.[16] According to the analysis, "17.8 percent of people with a credit report as of 2020 had medical debt in collections, and 13 percent had accrued debt in the prior year but were not yet in collections. Of those who had medical debt, the average amount was $2,424."[17]

The findings from SIEPR were consistent with the findings from the U.S. Census that showed "19% of U.S. households carried medical debt, defined as medical costs people were unable to pay up front or when they received care. Among households with medical debt, the median amount owed was $2,000, meaning half had more and half had less."[18] The current problems have been persisting for a long time indicating that the expansion of health insurance by the ACA has not addressed these issues. For instance, a 2008 survey from The Commonwealth Fund found

> that many people are struggling to pay their medical bills and have accumulated medical debt over time. In fact, 41 percent of working-age Americans—or 72 million people—have medical bill problems or are paying off medical debt, up from 34 percent in 2005. If you add in the 7 million elderly adults who are also dealing with these issues, a total of 79 million Americans have medical bill or debt problems.[19]

The Focus on Expenditure Controls Is Creating Barriers to Care

The fear of being exposed to large health care costs and the risk of falling into medical debt is impacting patients' willingness to seek care. According to a 2016 Kaiser Family Foundation and *New York Times* survey of patients, not only did 25 percent of Americans have trouble paying a recent medical bill, nearly one-third of Americans said they have delayed care due to concerns over the cost.[20]

The focus on expenditures has also led to policies that deny coverage, even in circumstances where a patient has already received the health care services. According to an American Hospital Association (AHA) survey,

> 89% of respondents have experienced an increase in payment denials over the past three years, with 51% having experienced a "significant" increase in denials. There are several different ways in which plans deny claims, including initial claim denials (or pre-payment denials), post-payment audit denials, partial or line-item denials, and down coding.[21]

Supporting the AHA survey results, a June 2021 survey from Harmony Healthcare of over 130 hospital reimbursement executives found that "across the nation, the average denials rate is between 6 percent and 13 percent, and over one-third of hospital reimbursement executives surveyed responded that their organizations are nearing the denials danger zone of 10%."[22]

Pollitz and McDermott (2021) used the transparency data on ACA Marketplace Plans to examine claim denial.[23] The authors found that "about 17 percent of in-network claims were denied in 2019, and about 14 percent on in-network claims were denied by issuers in 2018".[24] Of these denials, 18 percent were because the service was not covered, 9 percent lacked a required referral or preauthorization, and 72 percent for "some other reason."[25]

A particularly egregious example of this coverage denial problem is the growing practice of insurers declining coverage of a patient's emergency room visit. In the case of Anthem, the insurer implemented rules in 2017 that affected six states (Georgia, Indiana, Missouri, Ohio, New Hampshire, and Kentucky) that shifted the cost of emergency room visits to the patient if, upon review of the claim, Anthem concluded that the situation was not an emergency after all.[26]

United Healthcare, which is the largest health insurer in the US, has recently adopted Anthem's policy based on the justification that it would help hold down health care costs.[27] While protests from doctors and patients have delayed implementation of the policy until after the COVID-19 pandemic is over, Anthem intends to also review claims for emergency department care, which would also deny payment on a patient's use of the ER if the insurer determined that the situation was not actually an emergency.

According to the AHA survey, "failure to obtain a prior authorization was one of the most common reasons for a claim denial from a commercial health plan.

Then there is the problem of prior authorizations (PAs). According to the AHA survey, "failure to obtain a prior authorization was one of the most common reasons for a claim denial from a commercial health plan."[28] When implemented for medical purposes, PAs can make sense, but there is a growing trend of using PAs as a financial tool to ration care not for clinical efficacy purposes. PAs impose large financial costs and harm health outcomes when used for such budgetary purposes.

According to a 2019 American Medical Association (AMA) survey on PAs, 86 percent of the physician respondents reported that the burden from PAs is "high or extremely high", and 30 percent of physicians reported that they have staff who exclusively work on PAs.[29] Further, 24 percent of the surveyed physicians reported that PAs led to "a serious adverse event for a patient in their care" and 16 percent reported "that PA has led to a patient's hospitalization".[30]

In discussing the absurdity of many PA policies, the American Hospital Association noted that,

> to prevent harm and adequately care for patients, providers sometimes must begin treatment or move a patient to a more appropriate site of care before obtaining a response to a prior authorization request. In such instances, some health plans will deny care that they acknowledge to be medically necessary simply because the provider did not wait on the prior authorization processing. Additionally, if a health plan is reviewing an authorization request for treatment that already has started or occurred, some plans will adjudicate the request based on the patient's condition at the time of review rather than at the time the request was made. If the patient has improved due to the treatment received, the request will be denied as not medically necessary.[31]

From a patient perspective, rising denial rates, increasing administrative burdens (such as prior authorizations), and exposing patients to large financial risks unnecessarily decreases overall health outcomes. Such practices also violate the prime directive for insurance, which is to transparently transfer the financial risks of expensive medical procedures from patients to the insurance company. As such, the pervasiveness of these practices indicates that there is a fundamental failure of the health insurance system.

Conclusion

The fact that the medical debt problem remains at crisis levels while annual premiums for a family exceed $20,000 annually are clear indications that the U.S. health insurance system is failing to serve as an effective financial risk management service for patients. Instead of mitigating the financial consequences from the risk of requiring expensive medical services, health insurance excessively focuses on expenditure controls that, based on the continued excessive growth in expenditures, have been ineffective and harmful for patient outcomes. Consequently, fundamental reforms are required. Determining which reforms will improve outcomes, and which will make things worse, requires insights into how the incentives of the current system are driving the adverse outcomes detailed in this paper. This analysis is the topic of Part II in this series.

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