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Exploring Health Insurance Coverage and How it is Affecting Patients and Providers

By
Robert Balie Crim

A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

Oxford
May 2021

Approved By

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ABSTRACT

ROBERT BALIE CRIM: Exploring Health Insurance Coverage and How it is Affecting Patients and Providers

(Under the direction of Andre Liebenberg)

The American people are struggling to pay for or find good health insurance. Doctors are unable to prescribe them what they actually need. Their insurance might stop paying for the drug that they had been using that was helping them. They might have to try some amount of drugs or treatments before the insurance company will pay for what the doctor has prescribed. Patients might be having to endure more pain for an unnecessary amount of time at the hands of an insurance company. What are the roots of these problems? With the growing complexity and advancing technology, how are all members of the healthcare team navigating this increasingly convoluted insurance marketplace? Can this be fixed? In order to answer these questions, I researched literature and conducted interviews with healthcare professionals. These problems have come from excessive spending, government mandates, exclusive negotiations, and stifled market competition. Doctors and other providers have their hands tied when it comes to providing the best care possible for their patients, their main concern. Doctors are having to settle for not the optimal prescription, see more patients, do more work, combat reduced revenues, and jump through more hoops. There are some things we can do to help fix some of these problems. We can do away with the Medical Loss Ratio laws, improve market competition by doing things like eliminating the state line restrictions to selling health insurance, get practicing physicians more involved in insurance administration, and incentivize successful outcomes.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
KFF	Kaiser Family Foundation
MFN	Most Favorable Nation
MLR	Medical Loss Ratio
NAIC	National Association Of Insurance Commissioners
PBM	Pharmacy Benefit Manager

BACKGROUND

Mr. Smith is a 62 year old male. He has diabetes, heart disease, and high cholesterol. Mr. Smith has just moved to Oxford, Mississippi from out of state. He comes to a primary care provider in hopes to establish a new, consistent relationship with a physician so that he will have someone who knows what he needs. Mr. Smith prefers to have a physician that he can trust will always put the patients best interests above all else. It is also beneficial to have a physician who is familiar with the patient's conditions, familiar with what medications or treatments work best for a particular patient, and clearly just cares for the patient. Unfortunately, Mr. Smith comes to find out that his new employer's health insurance plan does not cover the diabetes medication that he has been on for the last 4 years. This medication that he has been on has helped him maintain great control of his blood sugar. "I have already been through the process of trying the different medications to figure out which one works for me personally. Everyone's body has its own tendencies and reactivities. I already know that the other ones do not work as well for me. What stings even worse about this situation is that the new insurer that I am now covered by even used to cover that drug but no longer does." Mr. Smith is left with a dilemma. He can either go with the next best option and consequently struggle with his blood sugar, or he can pay out-of-pocket for the drug he needs, which would cause much strain on his already struggling financial situation.

Mrs. Jones is a 62 year old female. She has a past medical history of diabetes, breast cancer, and hypothyroidism. Mrs. Jones is in the process of retiring. Once she does, she will no longer have access to her employer sponsored health insurance. So,

Mrs. Jones is about to enroll in Medicare. She is coming to the doctor out of concern for what her future medical costs will look like. She has had her diabetes under great control. She is scared that that will change. She is concerned because her breast cancer medications will likely land her in the proverbial ‘doughnut hole’ of her Medicare part D plan. If her drug costs reach a certain threshold, she is then responsible for out-of-pocket costs on a percentage of these drug prices that are very expensive. She is worried she isn't going to be able to afford this pitfall over the next several years.

Mr. Brown is a 56 year old male. Mr. Brown has a past medical history of hypertension, diabetes, and high cholesterol. He recently had switched to a new medication. Then, due to the Covid-19 pandemic, he lost his job. He no longer has his employer sponsored health insurance. With no insurance, he can no longer afford his oral diabetes medications. With no insurance, he is having to pay $740 per month for his diabetes medications that were only just barely keeping his hemoglobin A1C (average blood sugar over 3 month period) below 8%.

These are just a few of the recent problematic cases that a local internal medicine doctor was able to provide to me. Issues similar to these or worse happen every day, all across our country. What are the roots of these problems? With the growing complexity and advancing technology, how are all members of the healthcare team navigating this increasingly convoluted insurance marketplace? Can this be fixed?

In order to answer these questions, I first reviewed literature. Then I interviewed physicians and other healthcare professionals. Curious about what their perspective looked like, I wanted to see what these doctors had to say about these issues. I, as well as

the doctors I interviewed, realize that this is an extremely large and complex issue. It is unlikely that I or any one person has all of the correct answers to healthcare's problems. Some healthcare professionals think that it is impossible to fix. Healthcare will likely never be perfect. I am merely presenting what the literature and interviewees say. The authors that I read and the interviewees all have some differing opinions among them. In order to understand what is going on and what some possible solutions are, I think it is worth taking a look at their views of it. I am presenting what I found, whether or not I agree with it. The doctors presented to me the things that they see as problematic. They provided me with many arguments of their own. They gave me anecdotes that serve as either an explanation for something or as evidence that something is the way it is. A limitation of my research is that I did not get an interview from anyone who works for a health insurance company. So, as far as the interviews go, I am only hearing from one side. The words of the interviewees could be extreme at times. The health insurance companies did not get the opportunity to respond directly to me. In this sense, my findings are imbalanced. Another possible limitation of my research is the fact that in acquiring interviewees, a few of them came at the recommendation of an interviewee before them. This being the case, there is a chance that the recommended interviewees have views that align with the recommender. Another limitation of my research is that the healthcare professionals that I interviewed all practice in Mississippi. So, the interview portion of my findings are not necessarily applicable to every healthcare professional in the United States.

What I found from the interviews is that these doctors and healthcare professionals are frustrated. I am presenting the rest of the quotes in this section as a way to portray their frustrations and the details behind them. A business manager at a local clinic had this to say, “People are paying more and more for insurance. Premiums are going up. Deductibles are going up. Everything's going up. Yet, we’re getting reimbursed less from insurance companies. So it's like a win-win for the insurance company. They’re taking in more money, and they're paying out less money. I feel like the patients are suffering because of the lack of care and not being able to get what the doctor ordered for him. It’s like the years of med school didn’t matter.” This was the crux of the issues I initially was aiming to tackle. The lack of a say the doctors have over the care, the harm that brings about, and all that while private health insurance profits are steadily growing. In the literature and the interviews, I came to find out there are many more issues with American health insurance and healthcare as a whole. I was looking at a small part of much bigger picture. A local ophthalmologist painted the big picture like this, “Unfortunately it's been from the top down for quite a while now. Decisions are typically just sort of made at either legislative level, like at Congress, or at the CMS which overseas delivery of Medicare. Then it trickles down to private providers and insurance companies. There's a fair amount of behind the scenes negotiations that go on between the large insurance companies, legislative bodies in Congress, and what’s called Big Pharma- the Pharmaceutical industry. There's very little physician interaction or involvement with that. So we often just deal with the consequences of what those three, for a lack of a better word, collude to come up with for delivery of health care. That’s one

of the frustrating issues if you survey physicians about their happiness and in providing health care, that our hands are a bit tied. We don't have a lot of control or even input or say into what is going on in determining policy that comes back to affect that individual doctor-patient relationship. It affects our ability to pay their employees, and and to buy new equipment, and all the things that you need to to keep up with technology, which is advancing all the time. But, you know, the main problem is that affecting of the doctor-patient relationship. And all of those things affect that. If you don't have adequate staff, you've got a longer wait. If your doctors are overworked here, you're going to be there forever. It might take you three months to get in to see somebody. If you've got something serious, if you've got cancer or something that's got to be done then, you're behind by the time you you seek treatment."

While there are more aspects of why these doctors are frustrated, of everyone that I talked to, the heart of the concern was for patients and the sake of providing the best care possible. When asked about the manner in which health insurers are affecting patient care, a cardiothoracic surgeon replied, "They are driving care. They're really driving the way we practice. We have evidence based guidelines by our societies. However, a lot of that is dictated by what the insurers will pay for. So you have patients that maybe live in this community, but they don't have insurance that's taken. They don't cover the care here at this hospital and they gotta go to Tupelo. It's crazy. So I think that's a real problem. This this sounds kind of sad, but I think that the care that we deliver sometimes is not patient-centric and that's antithetical to really what it's supposed to be. It should be patient-centric The patient is our true North. But a lot of times it's driven by the

insurers. You know, even from a quality and cost standpoint. You would think that the insurers would also be patient advocates. I don't see an insurance company as a patient advocate. I'm a patient advocate as a provider. I've gotten on the phone and had to have discussions, sometimes numerous times, with an insurer to cover a care plan that is evidence based, that multiple physicians, multiple providers agree with, but the insurance won't pay. A lot of these folks, not always, but a lot of times the first answer is no. And then you have another hoop to jump through and they put up a barrier."

This displacement in autonomy is frustrating in itself. On top of that, it even can harm patients. In some situations, the patients condition can be worse off because of it. A physician said, "The term medically necessary gets thrown around a lot. But in reality of the practice of medicine we often find that it's just some government entity you're dealing with. Medicare, Medicaid, or a bureaucrat in an insurance agency gets to decide what's medically necessary. And so often patients aren't able to afford to pay for those tests that might be outside of what's covered, but are necessary. In my field people can lose their vision because of that."

Providers are being forced to bear an unnecessary weight. Some doctors are so backed into a corner that they take it upon themselves to provide a service for free. Though this is the right thing to do, it is still frustrating and can affect the ability to run their practice. The aforementioned physician also said, "They are unable to afford the test. I will often do the repeat tests free of charge just for the patient here. In other words, we're providing this service that we're not getting reimbursed for, which is time consuming. And really, it's it's unfair to the the practitioner in my opinion. But you know,

our hands are somewhat tied if we are bound by contract with Medicare or a private provider."

One of the most puzzling parts of this dilemma that the health system finds itself in is how the private health insurance companies are making more and more money, meanwhile America is having a healthcare expense and spending crisis. There is a stark contrast between the issues and the lifestyles that these health insurance executives are living. The morality and motives behind their actions are questionable and are worth taking a look at. An internal medicine doctor I spoke to was critical of the private insurers, saying, "These are for profit entities. I mean these big health insurance corporations… they have private jets. They they live very luxurious lifestyles. They're using the risk of a certain patient population for monetary benefit. So I think that there's a lot of moral and ethical issues with that. These people, these CEOs and administrators, and people that are making rules and regulations are profiting off of other people. It's almost exploitive. They have access to data and information that other people don't have, in terms of resource utilization, how sick their patients really are, who they are, who they decide to allow on their plan, and who they don't."

This same physician was also displeased with the disproportionate effects that the healthcare and health insurance structure's shortcomings have on people on a socioeconomic basis. Someone who is uninsured will be the ones who are proportionally affected more. Someone who has Medicaid or Medicare can possibly be the ones who are proportionally affected more. The difference between how much someone in those categories and another person who hypothetically makes a ton of money have to pay is

simply unfair. Someone who is uninsured could have to pay a full price charged by a hospital because they have nobody to negotiate on their behalf. Meanwhile the rich person has someone negotiating on his behalf. Someone with Medicaid or Medicare might still have premiums, copayments, or deductibles to pay that can significantly strain their finances. He went on to say, “That's what just infuriates me. And then the most vulnerable are left on the hook for that total change. The people that make a billion dollars a year should probably pay whatever the full charge is, honestly. But instead, those are the people that have the best negotiated price and pay the least amount. Whereas the person that has no money and doesn't have running water or electricity gets every penny taken away from him for this same procedure.” Another person who could be considered at a disproportionate financial disadvantage in this same hypothetical situation is someone who falls in the health insurance gap. Not only are there people who simply go uninsured because there are literacy issues, travel limitations, or some other social determinant, but there are some people who make too much money to qualify for medicaid and their employer does not provide health insurance either.

RESEARCH METHODS

I first conducted a literature review in which I searched through journals and publications for whatever I could learn about health insurance companies and recent trends among them. After that, I had an idea for what questions I wanted to ask doctors and healthcare professionals. Through the Institutional Review Board, I entered into their process of getting a list of questions approved and gained permission to conduct interviews with these professionals. The interviewees signed consent waivers prior to being interviewed. I conducted these interviews over a several month period, spanning from January to March 2021. I had 16 questions that I asked every interviewee. In order to get quantitative results as well as qualitative, for 4 of the first 5 questions I included the answer choices: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. I also encouraged the participants to feel free to respond with more than the provided answer choices if they would like. I interviewed 9 healthcare professionals in total: a pediatrician, a neurosurgeon, a cardiothoracic surgeon, an ophthalmologist, an Insurance Clerk at a local clinic, a Director of Case Management at a local hospital, a Business Manager at a local clinic, an Internal Medicine doctor, and another Internal Medicine doctor.

RESULTS OF QUANTITATIVE QUESTIONS

Table 1: Results of Quantitative Responses from Interviews with Healthcare Professionals

	Would you say that insurance companies are covering less medications, procedures, and treatments as of the past five years?	Would you say that insurance companies are affecting patient care?	Have you ever felt as though your knowledge or autonomy has been undermined by a health insurance?	Have you ever witnessed an insurance company's influence directly affecting a patient's condition?
Strongly Agree	22.2% 2 out of 9	55.6% 5 out of 9	33.3% 3 out of 9	33.3% 3 out of 9
Agree	55.6% 5 out of 9	33.3% 3 out of 9	55.6% 5 out of 9	55.6% 5 out of 9
Neither agree nor disagree	11.1% 1 out of 9	11.1% 1 out of 9		
Disagree	11.1% 1 out of 9		11.1% 1 out of 9	11.1% 1 out of 9
Strongly Disagree				

These healthcare professionals were mostly prone to respond with strongly agree or agree in response to these questions. 86.1% of the total responses given to all of these questions were either strongly agree or agree. For two of these questions, that is immediately concerning. The first one being, "Would you say that insurance companies are covering less medications, procedures, and treatments as of the past five years?" and the second one being, "Have you ever felt as though your knowledge or autonomy has

been undermined by a health insurance?" Out of the 18 total responses to these two questions, 83.3% of them were either strongly agree or agree.

The results of the other two questions are not directly as daunting. This is because these statements if true, are not inherently negative. The interviewees had their own perceptions of the connotation behind each question. For, "Would you say that insurance companies are affecting patient care?" two subjects expressed that the insurance companies are affecting patient care in a positive way and negative way at the same time. One answer: "I would say I strongly agree in the sense that it is the means by which patients get access to care. So they do affect it in that sense. Questions like that generally means affect it in a negative way. And, there are some barriers that require pre-approval." He then explained a lengthy example of how the regulations and hoops to jump through caused a waste of time and extra time of pain for a patient. In regards to that, he said, "You might argue that that's negative because like me, I think this is just dragging it out. Or it's making a delay." The other response carried a similar sentiment, "I strongly agree that they are affecting patient care. Whether or not that's positively or negatively is up to debate." Unfortunately though, when you look deeper at the responses to this question, the other 7 responses were with a negative connotation in mind, with 6 of those 7 being either strongly agree or agree.

In a similar sense, the last of the 4 questions, "Have you ever witnessed an insurance company's influence directly affecting a patient's condition?" does not necessarily indicate a negative manner. However, in all 9 of the responses, it was received with a negative meaning, with 8 of those 9 being either strongly agree or agree. Many of

the responses to this question came with examples of an insurance company's influence *negatively* directly affecting a patient's condition. For instance, one doctor explained how an insurance's decision, lack of coverage, or one of the other aforementioned shortcomings can cause a patient to become depressed. The same doctor explained another situation in which a health insurer won't cover inpatient rehab that they clearly need and subsequently their condition worsens because they had nobody at home to assist them or their living conditions are just so poor.

WHY THINGS NEED TO CHANGE

Right now there is an economic imbalance in the United States' healthcare system. Out-of-pocket costs, premiums, and deductibles have risen. Reimbursements of providers have fallen. Profits and profit margins of health insurance companies have risen. The financial negotiating power is unevenly and unfairly distributed. This economic imbalance has manifested into several problems. One of these problems is how health insurance companies are harming patient care and the well-being of patients. Insurance companies have claimed to be doing their best to control costs "while actually driving them higher." Despite your doctor's years of training, knowledge and familiarity of your unique condition or conditions, your doctor can be vetoed by insurance companies. By usurping doctors' wishes, "a patient's condition can deteriorate and lead to more costly procedures" (Lagrelius 2018). The insurers are exerting too much control over doctors and patients. "Today's system is largely controlled, in a top-down manner, by insurance companies" (Chapin 2020).

The problems insurers' control and power creates for the well-being of patients come in various forms. They are covering less drugs. The two largest PBMs in America are dropping over 300 drugs from their formularies. When the insurers drop a drug and suggest a similar one in its same class, the alternative drug may be a completely different chemical structure and have differing results from patient to patient. When I asked my interviewees, "Would you say that insurance companies are covering less medications, procedures, and treatments as of the past five years?" 7 out of the 9 agreed or strongly agreed. Most of them expanded on the reasons why or emphasized that this is a recent

trend. “I've really noticed a lot of medications not being covered, and so I would say yes. I would say that there's less coverage there maybe on diagnostic testing as well. I've been in practice for 20 years, like I said. And I didn't really see that big of a problem when I was starting out in practice. So, I think this has been especially in the last few years, maybe in the last four or five years.” One of the internal medicine doctors I interviewed drew attention to an interesting contradiction in regards to why they are covering less: “I feel like with the medications, procedures, and treatments in the last little bit, you’re starting to see some scaling back on what they're covering based on what it's costing to do those things as well as the research to do that. Now to me, in some senses, I see that the insurance companies are not taking a hit on their gains. So, it's an interesting phenomenon to see a lot less coverage, but yet they're still making their margins. So I agree, they are probably covering less. Some of that has to do with the cost, but others is them keeping their margins there.”

Stacey Worthy explains the issue well, “When insurance companies can use their power as payers to alter prescriptions, and dictate treatment decisions, it erodes doctors' autonomy and undermines the mutual trust that is the foundation of the doctor-patient relationship.” A study by the Doctor-Patient Rights Project in 2017 found that the health of nearly one in four insured patients treating a chronic or persistent illness—as many as 53 million Americans—may be in jeopardy by insurance providers who deny coverage for their treatments. More than one-third of those patients, moreover, cannot afford the out-of-pocket costs and may have to put off or forgo treatment altogether. People are having to spend more money out-of-pocket for drugs. “There was a sharp increase in total

and out-of-pocket spending on prescription drugs; total spending was up by $1,000 per person, a 38 percent increase. Out-of-pocket spending on drugs increased by 16 percent" (Davis, Schoen, Willink 2019). A survey in 2019 by the Kaiser Family foundation found that the average premium for family coverage has increased 22% over the last five years and 54% over the last ten years, significantly more than either workers' wages or inflation. These financial trends of the healthcare economy in America are not sustainable. Something has to give.

8 out of the 9 interviewees agreed or strongly agreed that their knowledge or autonomy has been undermined by a health insurance. Many of them expanded on the manner in which this has happened: "Whether it's the frequency of testing that might be needed, medication coverages, coverage for procedures, or reimbursement, basically the physicians are out of the loop on all of that. Which is troubling. We're basically just doing our job and hoping we're getting paid some fair fee for what we're doing. But we've spent, if you count college, medical school and residency, 12 years of our life training to have the ability to practice medicine and call my own shots. Which I basically have very little autonomy to do. So that's part of the frustration and thing that causes a lot of physician burnout, early retirement. Because we really have very little autonomy in the delivery of health care, and in particular dealing with health insurance and insurance companies, medicare included as well, so that's probably an area of frustration. I think if you interviewed any any healthcare provider, not just medical doctors, others would probably find similar kind of feelings." This doctor was right. Other members of the healthcare providing team see or experience the same things. The business manager of a

clinic told me, “They're dictating what the doctor can and can't do. The doctor thinks because of how they were trained and the science behind it, that this patient would benefit better on this medicine. But the insurance company is like, ‘No, they can't have it unless they’ve tried this one, this one, and this one.’ And so to me, it's like they are taking away from the doctor being able to make the decisions.” The insurance clerk of the same clinic is the one who deals with insurance companies over the phone. When asked about autonomy she said, “I have told them exactly what the doctor has said and why. And they say, ‘Well, we can’t approve that.’ Were you here with this man when he was having these heart issues? They're here, they’re laying eyes on the patient, and they're seeing the patient. You make a telephone call, and that person on the other end of the telephone call is probably just somebody like me. And they say, ‘No, we can't do that, because we have a list we have to go down. It doesn’t matter what the doctor thinks. The insurance company assumes they know better.”

A problem with a lack of autonomy and all of the extra obstacles in place is the way that this affects and infringes on the physician-patient relationship. A physician that I talked to said, “I really think that that the current state of things creates that situation that really takes away some of that physician-patient relationship where the two of them get to decide what's in the best interest of the patient and then proceeding along those lines.” The a good physician-patient relationship is important for the sake of good health of patients. “In some cases, the more that third party controls that patient physician interaction the more the patient maybe suffers because of that.”

Most of the people I interviewed brought up the fact that not only are insurance companies covering less things, but also increasingly putting up hoops for them to have to jump through. There is more paperwork, more phone calls, and more waiting on things to be approved. There is more labor required and therefore more time and money required. What one doctor said really exemplified how tedious and ridiculous they can be. "What's really hard is if you feel that you should do something for a patient that you've talked to, that you understand their social circumstance, and then you don't write it in your notes. And because it's not written in your notes the insurance company is going to tell you that you can't do what you recommended. But, then I go back and I amend my notes, and the insurance company lets me. It's almost a game." Some of them seem to think this might be even more detrimental to the patient care than what is and isn't covered, or at the least, had more to say about it. The business manager explained how these extra regulations can also affect logistics, like by making everything take more time and making patients have to travel around more. "They also have more requirements. You have to pre-certify everything. So that's more manpower, but you're still not getting reimbursed. And you're still waiting two or three days later before this person could have this. I'm talking everything, like an echo. You know, you have to go get this echo pre-certified before you can do it. Well you're not going to get that echo pre-certified today when the patient is here, because you're not going to get it through on the phone. And this one requires you to go on to their website and log it in, and this one requires you to fax it in, and you can't even get on the website. And yet, we've got an ultrasound tech that we employ that works here full time that could do that. She *could* go ahead and tell the

doctor what she saw before that patient leaves, and he could go ahead and pretty much treat them. And then we have patients who live within a 60 mile radius, so then they're having to come back. And again you're back to that thing where the doctor says you need this, but the insurance company is not sure the doctor knows what he's talking about. And then in the meantime, while I'm getting that pre-certified, did they get worse? Did they have to go to the emergency room? And the costs are going up, and your patient care is going down." Insurance companies are "bundling" things together more often now, or in other words, reducing the quantity of something they will cover. The insurance clerk explained one way that this new caveat can affect care: "Something that I've seen is on lab tests, they've gotten to where they won't pay for *this* lab test, if you had *that* one. For instance, drug screens and in urine, somebody comes in for a urine test because they have a UTI, but they also have to have their drug screen to get their Adderall. They won't pay for both of those, you know, because they're the same thing so they say. But they're not. They're two completely different tests. But they bundle it together and say, no. They bundle a lot now. It's totally different. It's not anything in connection with the other one. It's totally different. They're doing that more and more. They're bundling things together more and more." The insurance clerk also talked about another headache caused by insurance companies with labs. Some insurance companies will only cover a lab done at a certain place. They might take a sample at the clinic and having to wait for another place to assess it and send it back, making for two trips and appointments for the patient. The insurance might require that the lab be completely done at another place. So the patient has to go to the doctor, realize there that a lab needs to be done, do that at another

location, and have another visit back at the original place, making for three trips. There are even other examples of situations with more headaches or trips stemming from things like abnormal lab results, an unsuccessful lab, or just the other place taking too long.

This issue matters because someone has to fight for the people who are most affected. “It's the patients with the least economic and political power who will bear the brunt of our health care system's failings” (Chapin 2020). The lower-income patients are the ones with the greatest risk of having a high proportion of their income being spent on the out-of-pocket costs (Davis et al. 2019). Doctors are also affected and frustrated. Doctors have a stake in this issue as well, but doctors have their own political power to an extent. Doctors have a voice, and therefore have a degree of responsibility in this cause. However, the imbalance of power has shown that doctors’ political power is only so much. “If Congress intends any meaningful healthcare reform, lawmakers cannot continue to ignore the part insurance companies play in limiting access to care” (Worthy 2017). One doctor I spoke with is not happy with how the government’s involvement with health insurance, through the ACA and other laws regarding private insurance companies, has affected the quality of patient care. He agrees that doctors are in need of a bigger say in how things should go. He said, “I think there has to be some collaboration with everyone involved all the stakeholders and I just don't think that's what we've seen or what we're getting. It's very difficult for legislative bodies to figure out what's best for the doctor-patient relationship for delivery of health care, and that's what we've had, and that's probably what we're going to keep having.” Some examples of some more stakeholders he wants more involved are physician groups, medical societies, the

American Medical Association on a national level, other subspecialty societies which promote physicians in regard to what would be best for the physician-patient relationship along with the public and any government legislative body that's involved.

Not everyone is pulling in the same direction at all times. The focus needs to be on what is best for the patient. What is best for the patient is not always what happens because all of the “restrictions, limitations, regulations, or resistance to covering procedures.” One doctor who was explaining this went on to say, “I know horror stories of physicians who, for instance, treat cancer and deal with patients who needed a certain treatment, but insurance wouldn't cover that particular treatment just because they, for lack of a better way of saying it, didn't want to pay for it. And you know, there's been injury and death to patients that's occurred from that. And that's disheartening.” If patients are dying because of the shortcomings of our health care system and the way it is operated, that is not OK. Something has to change.

PATIENTS BEING AFFECTED

In the literature, I read about how these issues are resulting in a decline in quality of patient care. I wanted to verify the validity of these claims and hear what this may look like. I asked the healthcare professionals some questions that were geared toward doing just that. These questions, and even other ones, had a tendency to elicit a story or example of how a patient was worse off as a result of an insurance company's regulations, coverages, or actions. I mentioned earlier how labs are being limited in quantity. Well diagnostic tests are getting the same treatment. And in this situation, the testing limitations cause more than just an inconvenience, they might lead to a worsened condition. The ophthalmologist that I interviewed talked about how in some situations you might have someone that needs a diagnostic scan or test, but insurance won't cover it or limits the number of times it can be done in a time period. He has, for instance, glaucoma patients that need a test. That patient might have performed poorly in a test and needed to have another one done, but can't because it was three months ago and not a year ago. The doctor needs to be able to know whether they are losing their vision or not. How can the insurance company reasonably limit tests like these that give an assessment on a patient's condition? To limit a test like this to once a year is to assume that every single test will show that a patient is in good condition. It is like assuming doctors won't need these tests in order to get a patient back to healthy, but rather they will only need them to make sure they are healthy. On the insurance company's part it doesn't make logical sense, only financial sense.

Many of the interviewees, if they couldn't quickly recall an instance in which a patient's health condition or outcome was negative because of a health insurance, or even if they could, at the least attested to there being instances in which patients endured pain longer or a greater extent of pain because of a health insurance. The neurosurgeon said, "I just had a patient who had a significant delay in receiving the care that I felt that they needed, which just led to unnecessary pain on their part, an extended period of pain on their part." The hospital case manager said, "I think sometimes patients stay in pain longer, because they're not getting the tests they need to show what treatment would help them or maybe they need surgical intervention. But, we're having to try conservative treatment and therapy and that sort of thing before we find that out. I've just seen that over the past few years that the patients are saying, 'Well, I'm in lots of pain and I need this MRI.' But the insurance company they want them to wait until they have done the treatment to see if they get better." I asked for clarification on whether or not this used to be normal, and she said, "I don't think so. I think more so it used to be if the doctor ordered it, it got done. And there's still some insurance companies like that, that if the doctor orders, it doesn't require pre-certification, and it gets done. But I think some are managing their dollars better." Without knowing the percentage of these patients that legitimately get better before getting an MRI, maybe this is an instance in which the insurance companies are reasonably holding down healthcare costs. Even if we can give insurers the benefit of the doubt on that one, there are plenty of other examples of unreasonable and unnecessary prolonged pain, suffering, or illness. There are even examples of unnecessary spending on the insurer's part, just because of their stubborn

attachment to their regulations. The business manager told a story that was actually outside of the context of her job. She went through this experience with her dad. “My dad has high cholesterol. He hadn't been able to tolerate statins. He had the muscle aches, and was just not able to tolerate. So when they came out with the medicines Praluent and Repatha, he started on the Praluent. His cholesterol numbers improved dramatically. They went to normal within three months. Dr. [redacted] had actually been giving him some samples from here. So he wrote the prescription for the Praluent, and the insurance company would not approve it. He wrote a letter. He sent the insurance company copies of the labs to show the difference in the labs. My dad has also had stints in the past. So he's had heart conditions. But, they would not they would not approve it unless he went to a cardiologist. The doctor had these numbers to prove that this medicine worked with him, and the others didn't. Then we actually tried him on the Repatha. Same thing, it had to be a cardiologist or a lipidemiologist in order to write the medicine. So, he did end up going to a cardiologist. But that's more cost when the end result is the same. He is on the Repatha that the cardiologist is writing. And now he's going to see a cardiologist a couple times a year when Dr. Hill was doing a fine job of taking care of him. So the insurance company ended up having to pay more because they’re paying for those doctor visits.”

Another story from the insurance clerk shows how frustrating it can be when the doctor and patient know the inevitable outcomes, but the insurer makes them stay in pain longer and spend more money. “He knows this medicine is not going to work. But, ‘We don't care what you think. You've got to do this first before.’ Somebody is going in for a hip replacement. You've got to have that hip replacement, but you've got to do all these

other things first. This man who needs a hip replacement is suffering this whole time, because he's got to go through physical therapy and he's got to go through steroids, and he's got to do all this stuff. And he's going to end up having the hip replacement anyway. But not only has he suffered, but he's out all this other money and time because of all this other stuff he had to do before he could get to the hip replacement. Delay of care is suffering."

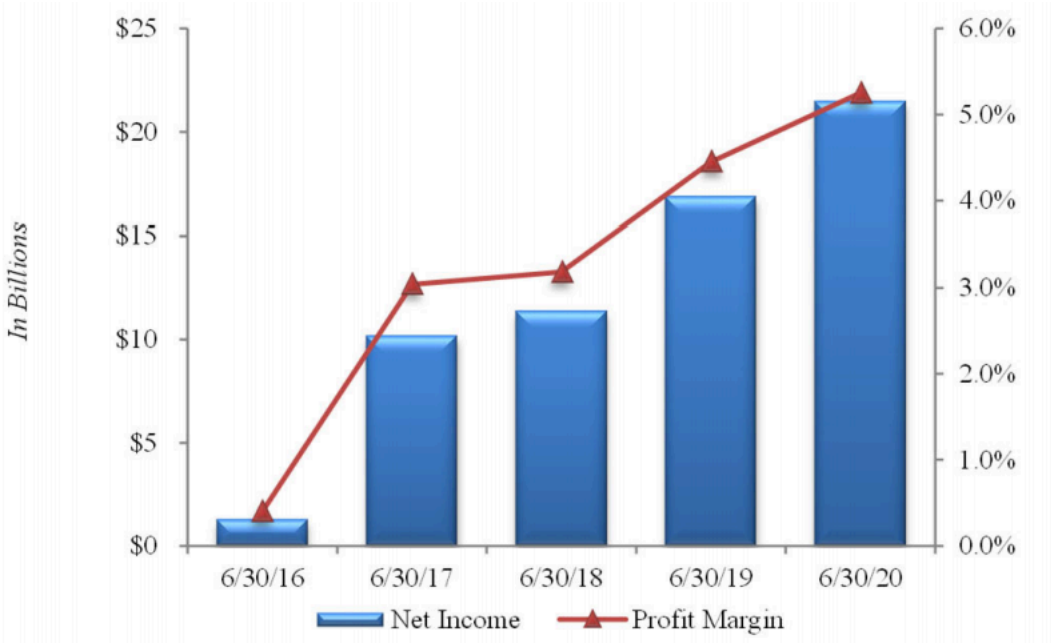
One of the internal medicine doctors I interviewed mentioned a form of suffering that I had not read or thought about before he mentioned it. "Depression would be one of them too. There's some antidepressants that are not covered that I think would be better choices that are just not available for people based on coverage. And then they can't afford it." When I asked this same doctor if he had ever felt as though his knowledge or autonomy had been undermined by a health insurance, he actually provided me with an instance in which the insurance required the patient to take a drug that the doctors knew was likely harmful: "Yes, in the last several years, certainly. They made us use step therapy for certain treatments. One of the step therapies is a diabetes medicine that if you're young and you take this, it's going to speed you up to where you're actually losing some of your pancreatic functions for producing insulin. That's something that didn't make any sense to us at all. And then there's other examples of that." This doctor had more examples of insurance companies requiring that you prove that other medications failed before they will pay for a certain one. There is a drug that is good for cholesterol and heart disease called Repatha, and some insurance companies are "requiring a patient to have an actual heart attack before they'll cover it." I wondered if the insurance

companies are actually paying more in the long run on this pool of patients by taking the reactive route rather than a preventative route. The doctor wasn't sure, but said he would be curious "to see what the numbers would look like as far as the outcome."

The ophthalmologist had even more examples of patient outcomes being negatively affected by health insurance companies. He had a couple of examples about medication coverage issues. In his answer, he mentioned insurance companies covering a medication for a patient, the medication working, and then they stop covering it while the is using it because they dropped it from their formulary: "One of the most common things that we see in in our practice is dry eye patients. We often fight with insurance companies to get one or the other of the prescription medications that help you make more natural tears. There are some patients that really are just plain miserable. Dry eye causes more than just burning. It causes pain, scratchiness, irritation, blurred vision, and difficulty functioning for some people to the point that they really can't get out in the wind or sunlight and function. We tend to fight with private insurance companies in particular. We interact with Blue Cross more than than most other insurance companies. We tend to fight with them quite a lot to get one of these medications covered. But I see patients kind of suffer in the meantime. Or, we'll sometimes have a patient on one of these medications and they're doing fine, and then the insurance company will decide to drop that off of their formulary of medications. So now the patient is either stuck paying for it out-of-pocket or just not having it anymore. Then often their quality of life is diminished, as well as their their vision. We don't really have a lot of good alternatives. I could give you a litany of patients that run into that in particular. And there are other things like that. For

example, in glaucoma we find sometimes that when patients either can't use or don't respond to some of the generic medications that are more commonly covered or less expensive, we often have to change them to something that maybe is brand name only that maybe is more effective. We often run into situations where patient has tried and failed therapy on generic medications that are covered and then we move on to try to put them on brand name medications that may be one of the newer medicines that doesn't have generic equivalents out there. We'll find that the the cost is prohibitive. We maybe have a a sample that they can try and we find that it's working to lower their pressure. But, then when we go to give him a prescription and and check and they check their pharmacy they find it's $300-$500 for a one month supply, one little bottle of medication, even with insurance. Most of these patients by the time they reach Medicare age are on fixed incomes. They don't have money set aside to cover one medication. There are often on multiple, sometimes 8, 10, 12, 15 medications. They can't spend $300-$500 on one medicine. But then they can't afford to go blind either. Those are just a couple of examples where it's impacted patient care. I've seen patients lose their vision because they had drops they couldn't afford, insurance wouldn't cover, and we didn't really have another alternative for him. And you know, once vision is lost from something like glaucoma, you can't get it back." It must be frustrating to have a drug or a sample of it, realize and have proof that it helps you, and then be told that you can't have it because the insurance won't pay for it and you can't afford it. The fact that this can lead to someone losing their vision is ridiculous. It is cruel. Eye sight is such an essential function. Nobody deserves to be blind because of a certain amount of money.

Figure 1: Mid-year Net Income and Profit Margin of Health Insurance Companies from: *Health 2020 Mid-Year Industry Analysis Report, National Association of Insurance Commissioners, 2020*



Health Insurance companies are experiencing increases in profit over the past few years. However, people have differing takes on the profits of health insurance companies. Some people consider the increasing profits as significant, while others downplay them pointing at the profit margins and how they relate to other industries. “Profits of publicly traded insurers have averaged only 3% of revenues over recent decades, compared with the 9% average across the economy” (Pope). Pope characterizes the profits as small by comparing them to other industries. But, these numbers are over “recent decades,” a broad term that ignores the trends of just the past few years. The National Association of Insurance Commissioners characterizes the profit growth as significant: “The health

insurance industry continued its tremendous growth trend as it experienced a significant increase in net earnings to $23.4 billion and an increase in the profit margin to 3.3% in 2018 compared to net earnings of $16.1 billion and a profit margin of 2.4% in 2017." Alexis Pozen proposes that their profits are just a product of the economic environment, citing a study that suggests "that their profits are more aligned with economic growth than anything else." Other authors are more critical of the insurers when it comes to their profits. "The Affordable Care era has been wildly lucrative for large insurers like UnitedHealth: Since the ACA was passed into law, the company's stock dividend has increased every single year, in tandem with the company's profits. Buybacks have soared. All this flies in the face of the insurers' protestations that they want to keep health care costs low" (Sammon). The clinic business manager that I interviewed said this about their profits, "I think the insurance companies are the ones who have come out on top in the last several years. So it seems like they're doing something right, or they've got the right people working for them and making the rules for them." Alexander Sammon goes on to further antagonize UnitedHealth saying they "even found enough money lying around" to buyback more of their own stocks. He also points out that their CEO got a 233% pay raise for 2019, receiving $52 million. And, another chairman received $50 million as well. Louise Norris is another author who characterizes the health insurance's profit margins as small by comparison to other industries. She mentions the legal, real estate, and bookkeeping industries having a 17% profit margin while the health insurers are getting single digit profit margin percentages. She points out that there are however "very profitable" sectors of healthcare including medical, diagnostic lab, and the

pharmaceutical industry. She says the health insurance industry doesn't share the same profitability since it is more regulated. However, the catch here, is that, yes, health insurance profit margins are lower, but their pool of money that these margins are a percent of is trillions of dollars. These pools for these other industries are billions of dollars. Profits are not inherently wrong or a sign of malpractice, but the problem here is the rise in profits in conjunction with the decline in the quality of the "product." I say product in quotation marks because it is unlike most things that we think of as a product. You can walk into a store and decide that you don't want a nice television because you can't afford it. You are not afforded a choice in whether or not you need healthcare or insurance. Nobody chooses to have an ailment. This, along with an accompanying decline in quality of care, are the reason that such rising profits are a cause of concern.

Jared Whitley uses the actions of the health insurance companies during the current COVID-19 pandemic to show where he believes their minds truly are. He finishes it off saying, "We all hope to come through this crisis stronger, but insurance companies are doing their best to make sure they come through it richer." The fact that private insurance companies are publicly traded shines a light on what their deepest motivations are. Even though it might make business sense for them, any publicly traded company has financial obligations it has to meet for its stockholders. One physician I talked to shared his frustration in regards to their motives, "If it hurts their bottom line, they don't want to do it. Like, the fact that there are health insurance companies that are publicly traded… so I could go invest in that. Maybe I should, you know, because they because they seem to be up to something that works."

In 2018, about one third of Americans had Medicare or Medicaid. 9 percent were uninsured. The rest of Americans had private health insurance with a split of 6 percent buying that on the individual market and 49 percent of that coverage provided by an employer, making a 55 percent total on privately insured Americans (KFF). Medicare and Medicaid do not pay the providers as much as insurance companies. An important thing when trying to understand the economy of healthcare is a grasp of the differences between charge, cost, price, and reimbursement. The charge is what the provider is asking for, which really could be anything and doesn't matter unless you are uninsured. The cost is what you personally are going to have to pay, like a co-pay for instance. The price is sort of two things at once. It is the fair market value that the providers say, and it is the fair market value that the insurers say. So, most likely those are two different numbers. The reimbursement is what the insurers actually give the providers. The providers don't have much negotiating power on the reimbursements, given the current state of the market competition. One physician I talked to explained these dynamics well, "So for instance, if Medicare sets a fee of $100 as being OK for a certain diagnostic test, and they may pay typically $80 of that. Well a private insurer may say, 'OK, we will pay more than Medicare. We'll pay $120.' Let's just say the fair market value for that service might really be $150. But you're not going to get $150 from anybody on it. You might get $70 from Medicaid. Medicaid is a state run program for more of the poor and disabled. It typically pays less than Medicare. So, we don't have any control over any of that. You know people will say, 'Oh, gosh, don't go to that particular doctor. Their fees are astronomical. What we charge is really sort of irrelevant. I could charge $1000 for that.

But if I'm going to accept Blue Cross, I'm going to get $120 for it. If I'm going to take Medicare or Medicaid patient, I'm going to get $80 or $70 for it. So it's just that set. It's outside of our control and it's frustrating. So there's there's very little free market in health care delivery already right now."

HEALTHCARE'S ISSUES

If profits are so great while giving poor coverage, one would wonder why there are not companies entering the market to offer better prices or better coverages and normalize the market. Well, there are companies entering the health insurance market more recently. The NAIC reported that from 2017 to 2018 the number of insurers went from 981 to 1,010. And the number has been slowly increasing since 2010, when there were 839. But is this growth enough to help? It would appear that this growth is not fast enough. There are still barriers to entry and barriers to success that are hurting the market competition and dampening the abilities of the new players to make a mark. Kaiser Family Foundation estimates that 22% of people going to the ACA marketplace will only have one option for which company to choose by the end of 2017. Additionally they say 21% won't find much better and their options will only be from two choices. Despite the NAIC's number of total health entities being on the rise since 2010, market share is still top heavy. "Meanwhile, the latest available data show that the percentage of the Medicare Advantage market controlled by the top four largest insurers increased from 48 to 61 percent nationwide between 2007 and 2015. For individual and group policies, the increase in the market share of the top four firms when went from 74 percent in 2006 to 83 percent in 2014" (Dafny). This is problematic. A study by Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan concluded that a merger between two major insurers in 1999 was responsible for lowered incomes for hospitals and doctors as well as growth in premiums. The biggest companies having the majority of the market shares gives them a lot of power and control. They are able to negotiate the prices and

reimbursement rates they want with hospitals and physicians because of their leverage over them. The health providers know that if the insurers don't include them in their network then they will get no patients. Insurers can get health providers to sign Most Favorable Nation or MFN Clauses where the provider is agreeing to not offer as good of deals to other insurers. Through this, the insurers are able to squeeze out the little guys trying to penetrate the market. A report by the Federal Trade Commission and Department of Justice explains that, "An MFN clause may harm competition either by substantially raising the costs of the insurer's rivals, or reducing provider discounting in the particular market."

8 out of the 9 professionals that I interviewed did not approve of the quality of market competition in health insurance. "I think that there's getting less and less competition in the market. So I think the insurance companies therefore can leverage their position a little bit more. So I think that's a key issue." One physician tied the lack of market competition to problems with access to healthcare: "It's not great. Blue Cross Blue Shield has been the dominating insurance in our market, as far as private health insurance. The problem I see with those guys is that their premiums are high. It's a disincentive for a lot of the working class to be able to afford that." There are some insurance companies out there other than Blue Cross Blue Shield, but they reimburse so poorly that providers can't accept their patients. The business manager of the clinic explains the ways in which market competition would improve things by making the dominant insurer raise its reimbursements: "It'd be great if we had somebody coming in that was kind of in the same range as our big one. I think then as more of those come into

the market and more people are buying their insurance then you're going to start to see that big player increase their reimbursements. But that hasn't happened. We haven't seen that. And the ones that we're not in network with are not trying to compete." More market competition would lead to an overall higher quality product, meaning that it would improve more than just the reimbursements to providers. You could start to see an insurance company covering more drugs and treatments in order to appeal to more patients and doctors. They might lower premiums, copayments, or deductibles in order to appeal to more patients.

The structure of the healthcare market is facilitating a vicious cycle of costs continually going up. "Experts frequently blame [the healthcare crisis] on the high prices charged by doctors and hospitals. But less scrutinized is the role insurance companies — the middlemen between patients and those providers — play in boosting our health care tab… In fact, they often agree to pay high prices, then, one way or another, pass those high prices on to patients — all while raking in healthy profits" (Allen). We have a triangular relationship going on, however the three parties each have a distinct tier in terms of the leverage they have in the relationship. The leverage of each party varies by geographic region and other circumstances like respective market share of a given party, but the order in which the party's leverage ranks is uniform. The patients get little to no negotiating power and limited if any choice in the way they play into the relationship. The hospitals and doctors have a little more options and alternatives. And the health insurance companies have the most influence and leverage of all three, with the mentioned insurers being the ones at the top of the insurer food chain. Marshall Allen

talked to Wendell Potter, “who left a career as a public relations executive in the insurance industry to become an author and patient advocate.” To me, this job transition is telling of the balance in healthcare. It speaks to it through the fact that someone from the health insurance side, from PR to boot, felt compelled to instead advocate for the people that were his target. In PR, his job was probably to paint the insurer in the most positive light to the patients, and he felt that there was a need for someone to help the patients instead. Potter goes on to say, “These insurers and providers have a symbiotic relationship. There's not a great deal of incentive on the part of any players to bring the costs down.” While Potter is speaking on a relationship between two of the parties as opposed to the three I am talking about, his words serve my point that the insurers and providers are the top two of the pecking order. Say a given insurance company that has the majority of a region’s market share of policyholders is negotiating with a hospital or doctor. That insurance company has the ability to say to that hospital or doctor that they don’t have to include the hospital or doctor’s services as a part of their coverage and then from there the majority of patients in the region will not go to that hospital or doctor. So, from there the insurer has the ability to get the reimbursement rates that they want. And when they get a MFN clause, that pushes away other insurance competitors. The reason I put the insurer’s leverage at a greater level than the hospital or doctor’s is because once they get into the MFN, that hospital or doctor is essentially locked into that marriage with that insurer. The bit of leverage or wiggle room that the hospital or doctor does have is the option to see that another hospital or physician group has the best deal in their region’s network so they merge or join them so that they then get the rates of that hospital

or group. Allen also spoke to Manuel Jimenez, who was a negotiator for insurers. Jimenez said, “Insurers can dictate the terms to the smaller hospitals. The little guys get the short end of the stick. That's why they often merge with the bigger hospital chains, so they can also increase their rates.” However this only further narrows the market shares of both the hospital and the insurer. The hospital has more patients under their umbrella now, but the insurer also in turn most likely has less competitors and more market share. The insurers that were previously insuring that smaller hospital or that doctor have even less or no more market share and thus have less or no influence on the nature of that network’s market. Or that smaller insurer merges with the one at the top, even furthering its influence. Then, the cycle starts over again. It’s almost similar to an arms race between the biggest hospitals and the biggest insurers of a region. The hospital sees the insurer buying the smaller insurer out and increasing its leverage so the hospital buys a smaller hospital or employs more doctors of the area. Or vice versa, the insurer sees the hospital increasing its market share and so it buys the smaller insurer to combat the other party’s increase in leverage. The Open Market Institute explains it like this: “Another effect of increasing concentration among insurers is increasing monopoly among providers. Hospitals are merging and absorbing doctors’ practices at a rapid pace for many reasons, but these include the need to match the growing market power of insurers in contract negotiations. Insurers in turn, see the growing monopoly power of providers in many markets as a reason why they must defensively combine into ever more giant entities, setting off a cycle of mergers leading to an ever less competitive health care sector marked by ever rising medical price inflation.” The patients’ ability to choose hospitals

and insurers accounts for how gradual this process is, but nevertheless they are getting less and less choice as this arms race cycle rolls on and are not able to know the details and results of the price negotiations. “Insurance companies may agree to pay higher prices for some services in exchange for lower rates on others. Patients, of course, don't know how the behind-the-scenes haggling affects what they pay. By keeping costs and deals secret, hospitals and insurers dodge questions about their profits” (Allen). Another part of the patients’ systematic weakness of leverage comes from the fact that they are not told the cost or price of their treatment until they go into the hospital or office. If there are competing hospitals or doctors, the competition between them is partially negated by the fact that most of the time a patient just goes in to one and takes the cost for what it is, because they are right there and don’t think it is worth it to explore other options. Allen mentions this and goes on to explain why it’s more of an issue now than before. “A decade ago, the opacity of prices was perhaps less pressing because medical expenses were more manageable. But now patients pay more and more for monthly premiums, and then, when they use services, they pay higher copays, deductibles and coinsurance rates” (Allen). I think it could be helpful for some policies and regulations to focus on this imbalanced relationship and focus on what it can do to create more balance.

There is another part to this cycle worth mentioning, even more evidence to the fact that insurers and providers have a leg up on the consumer. A majority of employer provided insurance is funded by the employer rather than the health insurance company. The health insurance company just acts as a service of processing and access to the rates they have negotiated with the providers. “Insurance companies may also accept high

prices because often they aren't always the ones footing the bill. Nowadays about 60 percent of the employer benefits are "self-funded." That means the employer pays the bills. The insurance companies simply manage the benefits, processing claims and giving employers access to their provider networks. These management deals are often a large, and lucrative, part of a company's business. Aetna, for example, insured 8 million people in 2017, but provided administrative services only to considerably more — 14 million" (Allen). Not having to pay for over half of the bills compounded with getting paid by these employers, the insurers have no reason hold the costs down. Paying the hospitals more makes them happy. And raising the premiums equals a bigger pie, which means the profits of the insurer are a bigger slice due to the medical loss ratio law from the ACA. The people at the short end of the stick are the patients and the employers having to shoulder these increasing prices.

THE REGULATORS

The laws and standards of the healthcare realm must be regulated by some body or someone. Authors and politicians both like to point fingers at certain regulators, pinning the blame on other politicians or groups of politicians. Although there are surely exceptions, I believe most people are too caught up focusing on just one or a couple of actions or regulations. This imbalance and what has caused it should be looked at with a broader and more holistic view of the sum of actions and regulations. “Premiums rose sharply in the final years of the Obama administration, as Trump officials like to point out, largely because of losses insurers suffered as they tried to gauge the health needs of their new customers. But after Mr. Trump and Republicans in Congress tried unsuccessfully to repeal the law in 2017, the president took a number of steps to weaken it, all of which led to uncertainty that resulted in insurers raising prices” (Goodnough). Both Abby Goodnough and Ricardo Alonso-Zaldivar both seem to be of the thinking that the lack of entry into the ACA marketplace and rise in premiums is due to the uncertainty that Trump evoked in regards to the future of the ACA. Insurance companies wouldn’t want to waste their time and money hopping into the marketplace if it is about to be changed or eliminated. A report from the Centers for Medicare and Medicaid Services says that in 2020 more insurers are entering the ACA marketplace and premiums are stabilizing. Alonso-Zaldivar goes on to point out that this stabilization coming from companies being more comfortable with the future of the ACA may be short lived considering the Trump administration is pushing for the Supreme Court to rule it as unconstitutional. A spokesperson for the Centers for Medicare and Medicaid Services

credits the improvements to the ACA marketplace to Congress for getting rid of the requirement that all citizens must have health insurance and to the Trump administration for instituting subsidies in a dozen states to cover some of the costliest patients.

While some put the blame on the insurers or both the insurers and the providers, there are some who disagree and believe that the majority of the blame is on the providers. For example Gerald Friedman says, “Some perceived the problem as a lack of market competition so governments freed hospitals and other health care providers from regulations on prices and restrictions on mergers, advertising and other practices. Far from reducing administrative complexity or lowering prices, research has shown that deregulation made both problems worse by allowing the formation of networks of hospitals and providers who use advertising and other business and financial practices to control markets and stifle competition.” He seems to disagree with a lack of market competition being a problem, given the following events he talks about. The problem with this argument though to me, is that the mentioned actions taken by the government sound like the opposite of what they should do to increase market competition. And it sounds like that is what happened… the opposite of an increase in market competition.

In my interviews, a few of the physicians were cognizant of the fact that providers have room to improve in this area. Wasteful spending is part of what drove us to this financial crisis. One said, “I think there's a lot a lot of waste in health care, a lot of waste. There's got to be a way of getting providers, not just physicians but administrators, everybody rowing in the same direction.” When asked about the problems in healthcare, another doctor added, “The other part that I think is important with healthcare is that

there is a lot of waste in spending in areas that need to be contained. I see so many problems in hospital and anesthesia costs and things like that that really drive up the cost of medicine. Emergency rooms, in a lot of those things you see the outrageous costs that are involved with it. That's what's driving a lot of the expense and therefore takes away from other parts of medicine that we need." He ended with a key point, that the wasteful spending in some areas ends up taking away from the rest of healthcare's pool of money to work with.

Louise Norris explains the medical loss ratio law from the ACA and how it caps the total administrative costs as a percentage of revenue. However, I believe the MLRs are ineffective, drive up health care costs, and that the insurers are able to work around them. She points out that "there's no similar requirement for hospitals, device manufacturers, or drug manufacturers," with the implication being that there should be because they are the problems. And some of that could be true to an extent. She secedes "that private health insurance companies pay their CEOs competitive salaries and they must remain profitable in order to stay in business." And then she adds, "But their profits are modest when compared with many other industries." In a different article, Chris Pope dives a little bit into the politics of the matter: "Democrats depict private insurers as hugely profitable and grossly inefficient. Yet in 38 states the largest insurer on the individual market is a nonprofit organization." Pope seems to, like Norris, also take the side of the insurers. Except, he says the majority of them are non-profit, which is a bit contradictory to Norris' assertions that they are profitable and that they must be profitable. Based on the way he frames the quotes, he seems to be critical of the

Democrats for placing so much blame on the insurers. Pope provides some of the Democratic presidential nominees' statements on the matter. "Private health insurers are the punching bags of choice in the Democratic presidential primary. 'The insurance companies last year alone sucked $23 billion in profits out of the health-care system,' Elizabeth Warren fulminated in a June debate. Kamala Harris charged in January that 'it is inhumane to make people go through a system where they literally cannot receive the benefit of what medical science has to offer because some insurance company has decided it doesn't meet their bottom line in terms of their profit motivation'" (Pope). It seems as though many authors believe that legislative action is the only way to solve our healthcare system's issues. "Without more direct policy intervention through price regulation and improved benefit coverage, Medicare beneficiaries will remain at risk for high out-of-pocket costs and potentially going without needed care" (Davis et al. 2019). One author differed in her ideas about what exactly the change brought about by the government might look like. In "How Doctors Broke Healthcare," Chapin expresses an affinity to the idea of direct primary care doctors and group doctors as ideas for models that could solve healthcare's economical issues. In a separate article, Chapin explains Hillary Clinton's and Donald Trump's respective ideas for fixing the system. Clinton is calling for a public option to government-run insurance. This could weaken the influence of insurance companies. Trump is advocating for allowing insurance sales across state lines, which would potentially create competition and cause insurance companies to have more incentives to appeal to consumers. Chapin also mentions that Republicans, given their disposition to market competition, might be more open to pre-paid doctor groups.

A few of the professionals that I spoke to were against government intervention in healthcare. They wanted as minimal of an amount of government involvement as possible. One physician was particularly adamant. One of the things he said was, “I’m not for government involvement in private business, and private lives of citizens either. I just don't think that that never ends up being long term helpful or positive. I don't think it helps control costs, and I don't think it it ends up leading to a net positive outcome. I think Obamacare has been a net negative outcome.” He says that it has actually caused lots of people to lose their their insurance. According to him it has also caused patients to lose their physicians. This is something that was promised that it would not do. He says that it hasn't held premiums or cost of care down, and that it's been a failure. He goes on to add, “All the government mandates to physicians and providers that came along with it have made Doctor satisfaction and health care provider satisfaction probably, I would say, if it's not in an all time low, it's probably close to that. There are more things that we are required to do, because government says you have to, more those things interfere with that doctor-patient relationship. The patient and the physician, to a certain degree, are in a loss. They've kind of suffered because of it. I think that that’s sad, but in my opinion, true. It’s just kind of the reality of the state of health care in the United States. Which is unfortunate, because I don't think it has to be this way. I think we've let politicians and government get too involved in health care, and a lot of the problems that we're seeing now are a direct result of that.” Though I think that frustration is valid, I think that government involvement is necessary in this instance. If something is wrong here that needs to be fixed, who else is there to fix it? I think that this is a situation that has hit a

wall, and the only change that could come about would have to be from legislatures or judges. The balance of powers has become stagnant in its imbalance. Although politicians or judges do not necessarily need to be the ones coming up with the ideas, they are the necessary means to a change.

One of the most impactful pieces of the ACA is the enforcement of medical loss ratios, which I mentioned earlier. MLRs pertain to how much money health insurers are allowed to spend on what. "As the system is currently structured, health insurers collect premiums from policyholders, money they use to pay for enrollees' health care claims, as well as administrative costs, marketing and advertising, and good old-fashioned earning of profits for investors. The medical loss ratio runs on an 80/20 rule, which requires most insurance companies that cover individuals and small businesses to spend at least 80 percent of their premium income on health care claims and quality improvement, capping the remaining money going to administration, marketing, retained profit, dividends, and buybacks at that remaining 20 percent level" (Sammon). What the ACA and the MLRs do is regulate the *profit margins* and hold those down, but does not necessarily tighten up on *profits*— the actual dollar amounts. Marshall Allen says they are "good in theory," but actually contribute to rising health care costs. I think he has a great analogy for how the insurers are able to operate around the rule and still grow their profits: "If the insurance company has accurately built high costs into the premium, it can make more money. Here's how: Let's say administrative expenses eat up about 17 percent of each premium dollar and around 3 percent is profit. Making a 3 percent profit is better if the company spends more. It's as if a mom told her son he could have 3 percent of a bowl of ice cream.

A clever child would say, "Make it a bigger bowl.” Wonks call this a "perverse incentive”” (Allen). For another perspective on this, I will reiterate: the profit margins from 2017 to 2018 only went up from 2.4% to 3.3%. But the net earnings went from $16.1 billion to $23.4 billion, which is a 45% increase (NAIC). So, while the profit margins are relatively tamed, though still increasing, the amount of dollars coming in as net income to insurance companies is going up by many billions every year. So, this money has to be coming from somewhere.

Most of the doctors could not fully remember the details of the MLR laws and asked me to remind them. Once reminded, most all of them were against the MLRs. However, there was one doctor who did not need to be reminded. He knew all about it and the problems with it. He explained the dynamics of it well. He had personal experience with it. He had been in the situation where he presents to the insurance company trying to help them keep costs down only to find out they don’t actually want to for the exact reasons that the MLR policies are a problem. Here is part of his rant: “I think an initial interpretation of that is, ‘Well good, this is going to force insurance companies to be more efficient in their overhead, in their administration. So let's just use a clean round number and say, OK, insurance company, they get a $1,000,000 in health insurance premiums annually for all the people that they insure. That means that they’ve got to take $200,000. And after they pay their CEO and everybody in that whole big building where that insurance company is, they have $200,000 to pay all of those people and what is left over is profit. So that is going to incentivize them to be very efficient.’ And that's true. There's a flip side of what this did that I think is an unintended

consequence. And that is, once this made up the insurance company that gets $1,000,000 in premium every year, once they have really kind of tightened down, become more efficient, really managed their overhead well, and they have trimmed down their overhead, now they only have one way to grow their profit. And that is to increase the premiums. So if you're covering a hundred patients and the premium is $1,000,000, well, OK, we're going to try to get more patients because that helps us. But the other thing is, can we raise our rates a little bit? We're still just covering a hundred patients, but now we're getting $1,200,000 of revenue. So instead of having $200,000 to split between overhead and profit, now we're getting $240,000. And we've already got our overhead reined in and it doesn't increase our overhead to raise premiums. So now we've got an extra $40,000 worth of profit. I've talked about this with a couple of my partners. And we've had pretty in depth conversations with executives at Blue Cross for sure, and trying to convince them that, 'Hey, look, we can really reduce your expenditures on spine care. You know, this thirteen doctor practice with interventional pain management doctors who are very conservative, physical medicine doctors who are very conservative, and surgeons who are very conservative. We can really, really, really reduce your costs.' Well, the problem is, if we reduce their expenditures, they can't keep any more of their money. Because they are limited to twenty percent. So it doesn't necessarily depend where they're sitting or depend on how much of their premium they're already spending on health care. They can look at that and say, 'Eh, yeah that sounds nice. That would be great. But we can't keep it anyway. Because the law says that we can only have a twenty percent margin.' We're talking about 20 percent that has to include overhead and margin. So now

suddenly, a private insurance company, who's actually assuming risk and insuring patients, doesn't care that much about the fact that I can save a whole bunch of money. ‘Send your patients to me, and I'll save you a bunch of money.’ They’re like, ‘Well shoot, we can’t keep it anyway.’ That's a tricky thing. Now, the people who don't face that consideration are employers who are providing health insurance and health care for their employees. All they want is to make is to spend less dollars and to make dang sure that every dollar they spend is being properly spent. So they care. So if I go to Walmart and I said, ‘Hey, man, I can reduce expenditures on spine care by forty percent.’ They’re all like, ‘Woah that's fantastic.’ They’re high-fiving. But if Blue Cross can’t keep that money, because the ACA has said so. If those guys save you a bunch of money then suddenly your combination of profit and overhead bumps them up to the twenty percent margin, you have to turn around to refund those dollars to the patients. You’ve got to send premiums dollars back to people. You can't keep it. Whereas an employer, if they can spend less money on care they’re keeping every nickel of that. That medical loss ratio thing on the surface seems like, ‘Oh, well that’s a great thing. Those insurance companies have to get more efficient and they can't get rich off the backs of patients, blah, blah, blah.’ But they also have the potential of being disincentivized to actually reduce costs, because if they’re in a market where they're dominant and they can therefore execute a significant premium increase, they'll take advantage of that. Remember, Blue Cross is not incentivized to reduce the overall cost of health care. They just want to make profit. If they reduce their expenditures and they can't keep it, it doesn’t do them any good. So it's a really interesting dilemma that was created by that aspect of that law.”

Two other major players in the dilemma that surrounds health insurance are adverse selection and moral hazard. These two factors require a masterful balancing act in order to be properly and effectively managed. Part of the trouble at hand is that many people seem to disagree or are having difficulties with perfecting the balance needed to bring the US health care system up to par. Adverse selection refers to the tendency or idea that the people who will be purchasing insurance are the ones who will need it more and therefore be more costly. A struggle lies there for insurers and policy makers to figure out how to prevent this and create balance to enable the sustainability of insurance. At the heart of the insurers objectives in regard to this issue is reducing the amount of unhealthy people you insure or charge them more or attracting the healthy people who will cost you the least amount of money. "In other words, the vital lesson for an insurer looking to make money is to identify the few sick people and get them to go away ("lemon dropping") and find the healthy majority and do things that attract them to your plan ("cherry picking"). Insurers are happy to offer discounts on fitness club memberships to attract healthy people, for example. But they punish the sick with higher copays and deductibles, as well as increasingly restrictive and intrusive regulations on preauthorization. Economists call it adverse selection. Regular people call it paperwork hell. Whatever the name, it's the purpose of increasingly complicated insurance plans and reimbursement forms" (Friedman). Elizabeth Davis acknowledges that adverse selection is a legitimate concern and threat to the economic feasibility of health insurance. It would not be sustainable for insurers to just ignore threat of it. Davis says, "If adverse selection were allowed to continue unchecked, health insurance companies would become

unprofitable and eventually go out of business." Davis talks about how in 2014 the ACA enacted laws that prohibit many of the methods used by insurers in the individual and small group markets to reduce adverse selection. This laundry list of policies include: prohibiting health insurers from refusing to sell health insurance to people with pre-existing conditions, prohibiting insurers from charging people with pre-existing conditions more than it charges healthy people, prohibiting health plans from imposing annual or lifetime caps on benefits, requiring individual and small group health plans to cover a uniform set of essential health benefits, health plans can't exclude certain expensive health care services or products from coverage, and essentially eliminating medical underwriting for major-medical comprehensive health insurance. These laws sound good and helpful for patients. The patients with pre-existing medical conditions are benefitted greatly by these laws, as well as just patients in general. These laws raise the question though: What effect does this have on the overall economic conditions of the healthcare market? The ACA also did still allow insurers to use tobacco use as a justified means of altering costs of the patient. Davis does add that there also however a big law that helped prevent adverse selection. The ACA required that all US residents must have health insurance or be charged a tax penalty. "This encouraged younger, healthier people who might otherwise have been tempted to save money by going without health insurance to enroll in a health plan. If they didn't enroll, they faced a hefty tax penalty" (Davis). However, the Tax Cuts and Jobs Act of 2017 ended this requirement starting in 2018. "The Congressional Budget Office estimated that the elimination of the individual mandate penalty would result in individual market premiums that are 10

percent higher (each year) than they would have been if the penalty had continued. That projected premium increase is a direct result of adverse selection, since it's healthy people who are likely to drop their coverage without the threat of a penalty, resulting in a sicker group of people left in the insurance pool" (Davis). This effect on premiums is not what we want to see. This also goes to show that this policy and adverse selection as a whole are relevant to premiums and have a relationship with the health care issues.There are at least a couple remaining ACA policies to help combat adverse selection. The ACA created certain time windows or special circumstances for when people can sign up for individual health care plans. This helps prevent people from waiting until they get sick or injured to sign up for insurance. These limitations on when you can enroll already existed in employer-provided healthcare and medicare, but individual plans were available all year until 2014. The ACA does also still allow insurers to base costs on a patient's age. This comes with the exception of a few states that don't allow this (Davis). This is relevant to the adverse selection in that older patients generally have more health issues than younger ones.

I asked the healthcare professionals, "In health insurance, what role do you see moral hazard and adverse selection playing?" Many of them did not know what the terms meant. These are mainly just insurance terms. Once I explained the meaning of each term, they either gave me an example of a situation that they come into play or just did not have much to say about them. The neurosurgeon explained, "Adverse selection certainly plays a role in the economics of health insurance in the sense that people who intend to or expect to need to utilize a lot of health care services will tend to choose more

generous health insurance policies with lower deductibles and lower copays and lower out-of-pocket expenses. People who see themselves as healthy and unlikely to need to utilize health insurance coverage tend to choose products with higher deductibles, higher co-pays, higher out-of-pocket in anticipation of not needing to use their health insurance coverage. And so it tends to drive up the cost of low deductible, low copay, low out-of-pocket products out of proportion to what would normally mathematically be the case, because those products are chosen by people who tend to use a whole lot of health care."

Moral hazard can be referred to as the tendency of an insured party to act in a riskier manner or ask for greater treatment because they have the safety net of being insured. "In the health insurance market, a significant number of consumers who have chronic illnesses choose more expensive insurance plans that needlessly drive up medical costs, a new study from Johns Hopkins suggests. Chronic illnesses account for 75 percent of health care expenditures in the U.S. While many cases could be treated with preventive care plans—which includes diagnostic tests and drugs to keep an illness from getting worse—most consumers opt for more expensive, "curative" care that includes surgeries and drugs that, while expensive, provide a major boost to the patient's health. The researchers found that about 14 percent of the people who would have been a good match for a medium plan and preventive care—that is, they were in moderate health, though they felt uncertain about their health status, and price likely would not be a factor in their purchasing decisions—nonetheless chose the more costly comprehensive plans and curative care. As Ni notes, this is an example of a "moral hazard," when a risk-taker is largely unaffected by the consequences of the action. In these cases, health care

consumers don't mind choosing a more costly care plan, however unnecessary, because they know that the insurer will pay for the bulk of it" (Ercolano). One way insurance companies combat moral hazard is by having less treatments definitively covered and having everything else be subject to review. Friedman mentions preauthorization, as I referred to earlier, but he categorized is as a means against adverse selection. And that is true and has its own merit, but some others characterize is more as a weapon against moral hazard. "In the United States, private health insurance sometimes excludes from coverage certain categories of care but essentially covers all treatments with any medical efficacy for illnesses that are covered, without any consideration of cost effectiveness. Specifically, almost all insurance policies cover "medically necessary" care, a term usually left undefined. If the insurance company refuses to cover a treatment recommended by a patient's physician, the law of at least 44 states provides the patient with the right to appeal the decision to an external review panel independent of the insurer. In almost all cases, the standard that the reviewer applies is entirely a medical one – i.e., whether the treatment is expected to provide any medical benefit – with no hint of concern for whether the likely medical benefits are justified in light of the treatment's cost, at least in the absence of a lower-cost treatment option that is equally effective to the recommended one" (Korobkin). Russell Korobkin has a good grasp and explanation of the dynamic here. However, I think as he explains the moral hazard dilemma present, he tends to fall on a side with the viewpoint that the patients are getting unnecessary treatment and care from what he characterizes as a big generous "medically necessary" net. Other people tend to view the vagueness of "medically necessary" as a tool of the

insurers to deny or slow down the granting of coverage for a treatment by it being easier to deny something if it is up for their interpretation. Both viewpoints are critical of the mechanism. Multiple doctors brought up the phrase "medically necessary" and the subjective nature of it themselves and mentioned how insurances use it as a means to deny requests. But, Korobkin puts the spin on it that the patients are causing strain on the insurers via moral hazard. "It is easy to see what kind of incentives this system provides: Patients who have low-deductible, low co-payment insurance will demand any and all pharmaceuticals and other treatments that promise any benefit at all, net of the risks and side effects of the treatment, without regard to cost. This is a standard "moral hazard" problem. And pharmaceutical companies, device manufacturers and health-care providers will price their products and services accordingly. Especially when the product is under patent, this system provides precious little in the way of a check on the seller's pricing power" (Korobkin). He has a pretty cynical view of patients and generalizes them as the greedy ones. He is acting like patients are getting whatever they want, saying "Patients demand any and all pharmaceuticals and other treatments that promise any benefit at all." He sounds to me like he is painting patients as entitled or spoiled or something. It sounds as though he has the idea that patients are getting whatever they want, when in reality the insurers are abusing the moral hazard concern as a means of having more control over patients, doctors, and what gets covered. But he does a good job of painting the picture of moral hazard's role in this dynamic. Moral hazard is an issue and it plays a factor in the issues of our healthcare. He does also make a good point about pharmaceutical companies, device manufacturers and healthcare providers which

brings up the imbalance of pricing power. He frames it as the patients getting whatever they want causes the pharmaceutical companies, device manufacturers and providers to raise their costs. While the cause and effects' respective roles may be up for debate there, it is a relevant dilemma to consider: the connection between moral hazard and rising costs of treatment. I feel as though his next sentence contradicts his picture of who is at fault when he says, "Especially when the product is under patent, this system provides precious little in the way of a check on the seller's pricing power." It sounds to me like the pharmaceutical companies and device manufacturers are the ones that need more regulation. When he mentions the patents, I don't see how that could include the providers, so I don't see how they have the disproportionate pricing power. When he acknowledges these entities have unchecked pricing power, I don't understand how he can spend more of the article pinning the blame on patients. But, like I said it is a good explanation of one of the ways moral hazard plays into health insurance. Korobkin wrote his article in 2014, so at that time the ACA was only just coming into effect. As we know, the requirement of everyone to have insurance ended in 2018. That being said, he speaks on that law that was at the time about to be in effect: "Under the Affordable Care Act, more people will have private health insurance coverage, and new breadth-of-coverage requirements (when finally enforced!) will mean patients will find that their policies exclude fewer categories of treatment. These reforms are net improvements, in my opinion at least, but they will exacerbate the moral hazard problem that plagues our health-care system and drives up costs." While I think he is correct here, it is worth looking at how the ways this law affects adverse selection and moral hazard clash. As

mentioned earlier, everyone having to get health insurance improves adverse selection, but it also worsened the problem of moral hazard if Korobkin is right.

Patients are not without fault. Patients, providers, and the structure of our healthcare system have a role to play in having gotten us into this crisis, but also in potentially getting us out of it. There needs to be more effort toward improvement as well as initiative towards better medical literacy. On moral hazard, the neurosurgeon added, “I think moral hazard plays a significant role in health insurance world. Patients are not financially disincentivized from unhealthy behavior. People will continue to smoke, not seriously pursue a smoking cessation program. People will continue to live well above their ideal body weight with no serious effort put into exercise and a healthy diet. Because they presume that any problem that might arise number 1, because doctors will be able to fix it, and then number 2, somebody else will pay for it. In this case, it's an insurance company.”

PATHS FORWARD

In my interviews, I had multiple questions that were geared towards evoking the healthcare professionals ideas for how to fix all of these problems in healthcare. I would ask, “What do you view as the biggest issue surrounding health insurance?” And then my next question was, “What would be your suggestion for solving this issue?” My next two questions were “What do you view as the biggest issue surrounding healthcare as a whole?” and again, “What would be your suggestion for solving this issue?” Later on after I ask about the quality of market competition in health insurance, I asked, “How would you increase market competition?” Through these questions and the interviewees sometimes having these thoughts come to mind when answering any question, I was able to compile a pool of ideas, big and small.

For the government, there is obviously some role to play in in getting these problems fixed, whether it be what they do or what they don’t do. A few of the professionals that I interviewed were pretty clear and adamant in that government mandates and requirements are not the way to go because they have always caused more problems. But, if the healthcare system is to be changed, who has the ability to open those doors to change other than the government? A key delineation on government “mandates” to be made here is that they are not all what someone has to do, but they can be what someone can do or doesn’t have to do. I think the professionals speaking against the government’s involvement were speaking towards things that someone has to do. And with that, I would agree. One of them had this to say about how government interventions have gone recently, “We've got a lot of failures in healthcare delivery in the system that

we're using right now. My personal opinion is that more government involvement is not the answer. For instance, when Obamacare came about, after Obamacare, and in the current state of medicine there has definitely been way more government regulation, government involvement, less autonomy by physicians and providers, less ability for insurance companies to have flexibility and leeway to figure out how to contain costs. So I've seen costs go up, coverage go down, and patient and physician satisfaction go down as a result so. I feel like you would hear that from other people if you interview other physicians."

One physician was in the minority in that he was an advocate for government intervention. He was on board with going to a single payer system. When discussing what he admires about England's single payer system he said, "I think that's one thing that from a humanitarian perspective, a single payer would benefit. Because there's this bioethical principle of utilitarianism of like, 'What is the real utility, and how do we distribute these resources to where everybody gets what they deserve?'" Another doctor is not as big of a fan of single payer: "I think the insurers are getting more power in the market because there are fewer and fewer insurers now. So I think they're getting power in the market. We're moving more towards single care or single payer. And then they are going to have a lot of power, and then we're going to really have a problem. Because then it's going to be you're going to be in line. You're going to be waiting." This same doctor goes on to specifically use England as an example of why a single payer won't work. The two doctors here apparently have different pictures of success in mind. He said, "From my perspective, there's a lot of things we could do to experiment our way forward and

figure out what are some better things to do as opposed to go to one payer. Because I can tell you, if you go to one payer there's gonna be rationing of care. And the reason is because that's the market, the way the market works. You know you think it's bad now with insurance companies. They won't allow you to do this, or that or the other. But that's the problem with monopoly. I mean, it's really a monopoly when you're only saying OK single payer. I don't think the American people will go for that. I think it sounds good, until you have to live in it. And you have to look at Canada and some of the other countries that have single payer, Great Britain."

Interestingly, the three of the doctors that I have just quoted all agree that there should be a government safety net for those unable to afford or get insured. One of the doctors that is against government involvement and mandates does not think that anyone should have to have insurance. However, he seems to think that should not be a problem or that it should work itself out because it would be foolish to go uninsured if you have the means to do it. He said, "I certainly think a young, healthy person should pay a much lower premium. But I don't think it ought to be a government mandate. And I understand young, healthy people not getting coverage. I think that they run the risk of something catastrophic happening like an accident, injury, cancer developing, or something like that. Which then, without coverage, could bankrupt someone easily with the current cost of health care delivery in the United States as it is right now. So I think it's foolish for people to not have health care if they're capable of having it. If they're incapable of of getting their own health insurance, then I would hope that that's why we have Medicare and Medicaid. If they are either from an income standpoint unable to afford health

insurance, then I would hope that they would then qualify for Medicaid. Medicaid is supposed to be a safety net for the poor and the disabled. And so I'm all for us having some government safety net for people that need it. And and I'm all for us providing Medicare which is for our elderly and our older population. So I think there's a place for those kinds of things for that." Though it is not necessarily a mandate of what people have to do, it is interesting that is is still a fan of a government safety net despite his disposition towards government involvement. That is with good reason, in my opinion. The doctor that was an advocate of government intervention had a main concern of getting every single person someone that will negotiate on their behalf. He said, "I think everybody should have some form of insurance, or at least some. If you look at the whole piece of the pie about how much we spend on health care, take the biggest chunk of that care in the hospital, I think that the government should pick up the tab or serve as a negotiator for all parties involved." The other doctor that was not in favor of government involvement or single payer had an idea for a government requirement that might help. He proposes that maybe requiring providers to see a certain amount of Medicaid patients would help with our issues of accessibility. He said, "I think there needs to be a social safety net. We have Medicaid. The problem is there are so many barriers and so many hoops that somebody has to jump through to get on Medicaid to get care. And then the other issue is there are a lot of providers that won't take it. I think that, and some states are looking at this— I think like 10 or 12, that if you have a medical license, you have to take a certain amount of Medicaid patients. What are these people supposed to do? So I

think that may be a reasonable experiment to do, see how that goes. We can do it as a pilot in a few States and see how it goes."

Two doctors made similar points points about how every government action taken that involves requiring something from somebody turns out to actually making even more problems or worsening things. One of them made this point while discussing his solution to the MLR policies. Simply, the MLR laws need to be removed. He does a good job of explaining why. He believes that the government should not control profits, but rather market competition. Not only will it remove their incentive of higher costs, it will have a positive effect on market competition as well. He gives a good explanation of what that could look like. Here is what he had to say, "I think it should probably be done a way with. I don't like, in general, a regulator or a government entity coming in and limiting the profit of a private entity. I would rather see private entities compete with each other. That's where having one insurance company that has basically a monopoly presence disrupts the market. Because it isn't much of a market if there's just one dominant carrier. My preference is to have a more robust marketplace of various selections because you have various insurance carriers in the community or in the state. Because if one of them wants to come in and, you know, instead of eighty percent, they're seventy percent. Well, that's an opportunity for a competitor to come in and say, 'You know what, I think we can make plenty of money at an eighty percent medical loss ratio. So we're going to come in and we're going to be more competitive than the company that is expecting and has come to assume that they will have this seventy percent medical loss ratio. We're going to have an eighty percent medical loss ratio. We're going to come in and be more competitive.

We're going to get more covered lives that way.' So my general take is that it's always better, when it's possible, for the market to take care of these matters and not for a regulatory entity to come in and prescribe these solutions. Because every prescribed solution from the government has, no matter how honorable the intent, had unintended and often unexpected consequences, like the one that you and I just finished discussing." Another doctor said almost the exact same things about good intentions of the government sometimes turning for the worst because they don't know everything about such complex issues as these.

Some of the doctors had similar ideas geared towards getting more parties involved in the negotiations that dictate healthcare in order to have more fair relationships. Physicians are silenced on the side while politicians, drug companies, and insurers are all financially scratching each other on the back. One doctor says breaking up that triumvirate might be the key to moving forward: "Like I called it earlier… even the word collusion has been thrown around a lot in the last few years. But, in my opinion there's a lot of collusion with politicians, big pharma, and insurance companies to control health care, to line all of their pockets at the expense of the patient and the physician. So if you can sort of bust that up a little bit, maybe there's your there's your way to start fixing the thing. And that's a huge task. Because, those folks paid the lobbyist to get in the politicians ears, to get in their pockets, to make sure they get what they want. And so you know there's really not much way to compete with that."

Many of these professionals had similar ideas for ways to increase market competition. Their ideas came either throughout the interview or when I specifically

asked how they would increase market competition. Many of them were a proponent of opening up state borders for insurance sales. In response to my question about it, one physician answered, “Allowing insurers to cross state lines and compete. I think more competition. Allowing more and more entities to come and to cross state lines is a simple way to increase competition. Allow somewhere out West to come into the Deep South if they can provide quality of care at a reduced rate but at better reimbursement. In other words, if there's somebody that can do it better, I'm by all means in. I'm for them coming in and doing it, wherever it is. But right now you you don't really have that. So that's one thing that I think that can be done.”

Another way that a couple of physicians suggested that we increase competition was that insurance companies offer more options or “individualized” care. If one insurer acknowledges that an individual or an employer has certain things they care more about being covered on, then that could force other insurers to also tweak their coverages, cover more things, and so on. One doctor answered, “I would say competitors offering more individualized products. So Blue Cross takes advantage of the fact that it's kind of a dominant player and it basically doesn't give employers very much leeway in how they design their insurance for their employees of that company.” Another doctor had similar ideas for individuals buying insurance, “I would let people shop. Why can't we? We shop for stuff, Amazon online, why can't you shop for insurance online? Why can't we do that kind of stuff? I think open it up to a free market. Open it up so that you can buy the type of care you need.’”

Another thing that would improve competition is transparency. So many costs and co-pays are veiled up until they are presented to you and it is time to pay it. Apparently, we are moving in the right direction in this regard. An internal medicine doctor said, “Charge is the big problem. This idea that I can make it up off of the top of my head. This is to the Trump Administration's credit, the hospital charge master list being public is great.” But unfortunately, we are not completely OK in this area. We can see what a charge is now, but not necessarily why a charge is what it is. The same doctor said, “The fact that it costs $10,000 to sleep in the ICU, just to sleep in the bed, the sheets probably aren't included in pricing, that is a problem. And that’s just a made up number like it doesn't cost that much. I mean, yeah, you have to pay the nurses you have to pay to clean it. You gotta do all this stuff, but nobody really knows how much it actually cost to sleep there. That’s how much they’re going to charge you, but nobody knows the actual numbers. Or they won't release that information for fear that it may not be $10,000.”

In my time researching literature, I saw ideas about what roles large companies like Amazon, Google, or Walmart could potentially play in healthcare. I wanted to know what the professionals thought about them maybe coming in as either health insurance companies, health providers, or both. I asked them, “What is your view on possible new competitors like Google, Amazon, Walmart, etc. in the healthcare industry?” Most of the interviewees were in favor of the idea of them coming in to improve conditions by creating more competition, but most of them also had reservations towards them. One doctor said, “Now, I do think that the effective solutions to the rising cost of health care that exceeds the rise in the rate of inflation is going to come from private industry. It’s not

going to come from any governmental intervention. And so I mentioned Walmart specifically, and I think they have proven with what they've done with spine and tunnel joints and cancer care that they can do exactly that. They have a huge role to play. I think we need to have as many innovators as we can possibly have in health care to help us meaningfully improve the product that we're providing to patients and also reduce the expenses associated with it. I think it's great. I think those guys are far more likely to find meaningful solutions than the federal government is."

Going back to improving access to care, one doctor emphasizes how these big companies have the opportunity to do that: "OK, so we talked about access as being a big problem. That's why these other players in the market are great. They're disruptors in this market. Why is this market ripe for disruptors? Well, because we've done such a poor job. We've built these huge cathedrals, bricks and mortar. They provide the care. But hopefully this will just be for a very small portion of our population that really need acute care. Then have these small clinics around where people can get their care, so they can stay out of this place. I think the Googles, the Amazons, the Walmarts are going to give population based healthcare where they want to get it. So they're bringing health care to the people. That is good." I think it is an interesting opinion from a doctor for him to say they need to keep patients out of there. They should want to see as few patients as possible at the hospital. Given that patients are their source of money, I think this shows a lot of foresight to understand that in the long run a healthier population means more money to go around for better reimbursements. But then again, any doctor's primary concern probably is or should be patients' well being.

Most of the doctors' reservations toward these companies had to do with quality of care and their motivations. One internal medicine doctor put it like this, "In general with that, those companies do a good job at a lot of things. But, healthcare is a different animal in a sense of taking care of people. Amazon, Walmart and Google are basically bottom line companies. Their money and how they can make money is their primary drive. So, I would be wary of that. The lack of personal touch and some of the things that go along with these big companies would to me be a detractor." Money being their motivator was a concern to him, and that is a fair concern. Other doctors viewed that as a positive in that them flexing their financial expertise would equate to them fighting to provide the best option, and that would lead to better prices and breadth of coverage.

A few doctors touched on the subject of what countries the United States could maybe take notes from. But, this conversation can only go so far because of how unique the United States is. In thinking about other countries' healthcare systems, the cardiothoracic surgeon said this, "It's comparing apples and oranges. The United States is very diverse. The people are different than they are in Canada. There's a lot of Canadians that are coming here to get their healthcare because they don't wait in line. Germany is a 2 tiered system. I don't know a lot about it, but I studied it little bit and when I was in grad school. But people pay for it. So there's the haves and the have nots, also. You know, Great Britain, forget it. That's not working. Singapore's got a pretty good system. But again, we're not a small little country. Until you get a commission in there that's going to just say this is what we recommend. If you make everybody unhappy a little bit you probably found the right answer." I think his last sentence is a wise proposal. In a system

like this, in dire need of equity and equality, everyone is going to have to accept a little give and take.

Another hot topic amongst healthcare professionals for improving the system was in one way or another reducing the costs of healthcare. A physician said, “The problem is medical costs keep going up. So that’s what drives insurance up. I don't have it. I don't know the answer to the problem other than trying to cut medical costs. But then you get into the problem of denying certain procedures or medications for people. So it's really tough. I don't know what the final solution is. Just trying to trying to cut medical expenditures I think would be some of the solution.” The neurosurgeon I talked to outlined two keys ways in which insurance companies can reduce costs. They can optimize their utilization management. Or, they can pay the providers less, which they have been doing. And the second option has not been working. Another thing that better utilization management can do is help you out against competitors. He explained it like this, “So, I think a competitor competing against a dominant insurance carrier that has weak utilization review in place can become an effective competitor in that market. Because if they can rein in utilization, then they can offer a more cost effective product to them. And another way to rein in the expense is to reduce the reimbursement, reduce health care spending, reduce what you pay the hospitals, reduce how much you pay the surgeons. The problem is that that's what the insurance companies have been doing for two or three decades now. And it just has not worked. There are plenty of marketplaces where they pay physicians and physicians in particular very poorly. Private insurance companies will pay physicians Medicare rates, which are just awful. But the overall cost

of health care has to come down. Because what happens is in the setting supplier induced demand, which is somebody comes into your office, the only way they know whether they need surgery or not is what the doctor tells them. And you've got physicians who's judgment is affected by the financial aspect of it. And so now they're like, 'Oh, we're going to pay you twenty percent less.' Then it's, 'Gosh, I've got to do twenty percent more surgery then.' In order to keep my head above water, in order to stay level, not in order to do better or grow, but in order to just stay where I am, I've got to do that. So reducing what physicians are paid has not been an effective means of reining in the costs of health care. But utilization or managing utilization and keeping people from having procedures or tests that they really don't need, I think can be very effective in reducing expenditures and therefore making that insurance company who is willing to do that much more competitive in the marketplace."

Towards the end of the interviews, I asked the professionals, "Are there any particular health insurers that you think are doing a good job?" I was interested to see if any answers were, "No," and there were. But mainly I wanted to hear what good things that insurers are doing so that maybe those could be things that they can focus on or spread going forward. The neurosurgeon explained how, for his practice, they are doing a good job of incentivizing success, and how they could do it even better. He said, "We have a contract with Blue Cross Blue Shield of Mississippi for bundled payments for the large majority of the surgeries that we do, one and two level cervical discectomy infusions and then lumbar decompressions, to do them in an ambulatory surgery center, which is a more cost efficient place to provide the care. Translation of that means the

insurance company pays less. The ambulatory surgery center can take a smaller payment and still turn a profit as opposed to the hospital that carries with it a lot of unnecessary overhead. And so here in Mississippi, Blue Cross Blue Shield of Mississippi has a bundled payment arrangement with my practice and the ambulatory surgery center that's right next door to it. And so when we take care of a patient, we get a fixed amount of money. They send it promptly. The anesthesiologist gets a fixed amount. The surgeon gets a prearranged amount. The ambulatory surgery center keeps a prearranged amount. And then if the patient has a complication, then the surgeon and ambulatory service share risk and can lose twenty percent of what we are paid. So it's a nice way to incentivize, as if we really needed it. Honorable surgeons, don't want to have complications because they care about their patients. But this monetizes and incentivizes in a financial way against having complications. And I would argue that we would be better off… I wouldn't mind if they paid us more upfront, but instead of placing at risk twenty percent, they placed at risk one hundred percent. So that way when you have a really bad outcome, then you might lose it all. But if they're paying you more per case, if you're doing a really good job, and you're having low complication rates as a surgeon, you'll still come out better long as you negotiated for an appropriate increase in the typical pay for a case."

My question for this idea of basing pay on success is, who is going to be the judge of success here? The doctors probably believe they are the best judges of what an outcome or condition is. The insurers don't know as much, but it is in their financial interest in this situation to say the doctor failed and the patient is not OK. And are the insurers going to hire people to out and look at the patients and judge them? I suppose, if the patient comes

back and the doctor needs to prescribe a certain drug or surgery to solve the complication, then the doctors can't hide that from the insurance.

The pediatrician and an internal medicine doctor both were complimentary of Blue Cross Blue Shield's initiatives to promote healthier lifestyles and taking preventative measures. One of them said, "I think that there's incentives that can be done for people. Whether or not it's the healthy people, giving them incentives for coming in and getting their checkups. The only way you're going to solve a lot of the problems, especially in the deep South, is prevention, nutrition, and all the things that can really help. I've seen in my practice a little bit of nutrition training is huge as far as impacting blood pressure, cholesterol, sugars, and overall health in general. That to me would make a big difference there." While these measures are great and at the least a good idea, the insurance clerk was not sold on how well Blue Cross is executing these initiatives. When asked if there were any health insurance companies doing a good job, she said, "No. One of them, they put it out there like 'Oh we're all about patient preventive health.' And it is 20 times more work that you have to do. And they pay for less services on a preventive exam. Somebody comes in for their preventive exam. They want everything done. And, well, your insurance doesn't pay for that. These are things like PSAs for men and pap smears for women. They don't pay for PSAs at all. They don't pay for pap smears. They just have different stipulations. Used to be that you could get one of those every year, then once every three years, and now not at all. It depends on if you've had abnormal ones." So, it seems there is still room for improvement in their preventative campaign. But, I think they have made a good start.

One of the internal medicine doctors thought that insurance companies need more physicians, that are actually in the field practicing, involved in their advisory committees and helping decide what should be covered and how much they should be reimbursing for it. He said, “One of the things that I see that the insurance companies have done is at the administrative level, they have people that are really not practicing physicians that are making the calls on those. I think they have people in place, it may be a physician, but they haven't really dealt with the ins and outs of these issues. They need to have people on advisory boards or panels of people that really get into the actual practice to see how things affect the patient outcomes. So I would say putting actual clinicians on those advisory boards that really manage that, more than just a person that's maybe an MD that was a surgeon or something like that who doesn't practice diabetes management or something of that nature.”

The other internal medicine doctor had an idea for getting rid of the employer sponsored health insurance structure. He was not necessarily suggesting it, but rather curious if that would work and how that would play out. He makes the point that this was established after a World War, and that this system is antiquated. In a “gig economy” with things like Uber, Lyft, and just any freelance workers, maybe employer sponsored healthcare is the most conducive option today. This doctor, as well as the ophthalmologist, contemplated a possible to return to boutique, subscription, or cash based doctors. There are some doctors who are starting to offer this, enjoying their jobs more, and are more successful. While it could lead to some good things like preventative care and individualized care, both interviewees say ultimately it is not the way to go.

What do you do when you break your arm or are in a car wreck? Another problem is that this could widen the gap between tiers of payers even more. The people with money are getting this good care. Meanwhile, the people without money are left to shoulder the weight of the premiums of insurers, and the insurers are left to shoulder the weight of the most unhealthy people.

CONCLUSION

Patients in America are struggling to make ends meet when it comes to getting the medications, treatments, and procedures that they need. What are the roots of these problems? There are many factors that have had a snowball effect leading to the United States' current state of healthcare. We have an antiquated healthcare structure that has been exploited to the benefit of a select few parties. The American healthcare system did not do a good job of containing costs. So, something had to be done. The government has been continually regulating the system and mandating all different kinds of things. In time, two parties have benefitted from this system and become disproportionately profitable. Pharmaceutical companies and insurance companies have been able to use their money to stay in the ears of politicians and become even more profitable. These one sided negotiations have led to some more direct issues for Americans trying to receive good treatment. Market competition has been stifled, the MLR laws are growing these issues, accessibility has been a problem, premiums are too high, providers are getting poorly reimbursed, and insurance companies are just not covering everything that they should.

With the growing complexity and advancing technology, how are all members of the healthcare team navigating this increasingly convoluted insurance marketplace? Well, essentially, they are just taking it on the chin. Over the past decade, some doctors are working more, seeing more patients, or doing more surgeries in order to maintain their finances. Other people who work for providers are having to do extra paperwork, jump through more hoops, and make more phone calls, as well as the doctors themselves.

Some doctors are even doing pro bono work, because the patients' well being is their main concern, but this makes it hard to run a business.

Can this be fixed? I think so. I know that at least there are some things we can do to get things headed in the right direction. Some professionals that I interviewed were at a loss for any solutions or just did not think that this can be fixed. But, most of them at least had ideas and suggestions for how to improve things.

After the literature review and interviews with doctors, I have my own ideas for what needs to be done. I think first and foremost, the Medical Loss Ratio policies have to be overturned. There is evidence in the literature and in my interviews that insurance companies are exploiting this law to expand their profits in exchange for growing healthcare costs. Restrictions on selling health insurance companies across state lines should be eliminated. This would improve market competition. I think that a free market and more competition is the answer to improving the conditions of healthcare. We need big companies like Amazon, Google, or Walmart to come in and push around the big insurance companies that have been so protected all of these years. We should put in place mechanisms that incentivize success for doctors wherever possible. This does not necessarily work in every situation, as circumstances are different for different kinds of doctors. Health insurance companies need to have more practicing physicians steering them towards what they really need to cover. I liked the idea of the federal government providing subsidies for states to help cover some of the more costly patients. I agree that we should take away the age requirement for Medicare. This will water down the risk of the Medicare pool while bringing in more money. This could help the people in that gap

between Medicaid and being able to pay for a private insurer. In a place like Mississippi, where we have seen that Medicare is better than the obscure private insurance companies, this has a chance to especially help. Finally, I personally had an idea that while opening up state borders for health insurance companies to offer coverage, it should be done conditionally in a way that forces them to cover some places that are lacking coverage. No insurer is going to want to come in and cover the Mississippi Delta. So, in order to look out for populations going without healthcare, the government could mandate that for an insurance to be allowed to sell wherever they want, for every X amount of profit that they make, they must also in turn operate at an at least smaller X amount of loss in a healthcare desert.

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