Delay, Deny, and Defend: Reassessing the American For-Profit Healthcare System

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Abstract

The response to the killing of the CEO of UnitedHealthcare, one of the largest healthcare insurance providers in the US, indicates the growing dissatisfaction among Americans with the for-profit healthcare and insurance system. Due to insufficient funding for federally provided healthcare plans like Medicare and Medicaid, most Americans rely on private insurance to cover medical expenses, resulting in varying coverage and costs. Because of the privatisation of a significant portion of this sector, many individuals are burdened with mounting debt from comparatively minor procedures, such as treating broken bones. This paper will explore the current medical climate in the US and identify key mechanisms that reinforce this for-profit system. Given that transitioning to a universal healthcare system is widely unpopular, at least among politicians, this paper will propose changes to alleviate and improve the current conditions. These changes include introducing price caps on life-saving medications and treatments, as well as preventing insurance providers and hospitals from colluding to raise prices. The current chargemaster, a hospital's list of the prices billed to patients or their insurance, requires a revamp, as prices are often marked up by hundreds of percent. Additionally, private insurance must be held accountable for its profit-driven management style, and reformation is a necessity to prevent a potential riot against the system as a whole.

The Failed American Healthcare System

Following the assassination of the CEO of UnitedHealthcare, the public response was mixed, with much of the discourse surrounding it rather in favour of the assassin or at least an understanding of why someone would target one of the largest healthcare insurance providers (Makuch, 2024). But how did the US get to this point where there is so much resentment towards the healthcare system and private insurance providers? Since the end of the Second World War, the US government has adopted a hands-off, almost laissez-faire approach to the healthcare industry, allowing the private sector to take over much of the industry. This was largely due to the genuine belief that the private sector would lead to increased efficiency, greater innovation, and less bureaucracy, but was also heavily influenced by the American Medical Association (AMA), which lobbied against universal healthcare (Alsan et.al, 2024). While still having some federal healthcare programs, such as Medicare, Medicaid, and Veterans' insurance for the most

vulnerable and needy, the government only offered healthcare to those most in need and lobby groups such as the AMA were able to alter public opinion on universal healthcare to the point that the term to this day is still somewhat controversial. While not done directly, AMA and a public relations firm, Whitaker and Baxter's Campaigns Inc., were able to rebrand private insurance into a message about individual choice and the government trying to take over the consumer's choice, which during the post-war era invoked fear in many (Alsan et.al, 2024). This also coincided with the rise of employment-based insurance, making the need for publicly funded insurance sound unnecessary to many (Smith, 2024).

After almost eight decades, the US is currently the only high-income nation to not guarantee its citizens healthcare coverage, the health spending per person is almost two times the amount of the country in second, and has one of the worst healthcare outcomes out of all high-income nations (Gunja et. al, 2024). Beyond the poor healthcare treatment, one study found that, of the more than 200 million Americans on private insurance, every one in seven claims were rejected by the insurance companies (Pollitz et. al, 2023). Employees of insurance companies were told to follow the motto of sorts, "deny, delay, and defend," which allowed for the company to maximise its profits at the expense of millions of Americans (Rissman, 2024). This, combined with the fact that healthcare prices in the US are absurdly high, means people have to pay out of pocket for their treatment, which can easily range from a few hundred dollars to a couple of hundred thousand dollars (McNaughton, 2023). Americans in total have around $200 billion in medical debt, and around 3 million people have over $100,000 of medical debt, which is approximately 4% of the US population (Rakshit et. al, 2024).

The reason why the medical debt incurred can be so high is due to the standard charges document, most commonly referred to as the chargemaster, which is a long list of all the billable items and treatments at a hospital that is negotiated with insurance companies. This list relates to the amount that hospitals would charge the insurance company, but if you are outside of your coverage or you simply do not have insurance, the actual value billed to you can be significantly higher. The chargemaster has already been found to charge from 10 to 20 times the amount that they would charge a patient on Medicaid, and the published chargemasters are actually only a fraction of what people pay (Arvisais-Anhalt et. al, 2021).

Previous Attempts to Address the Problems

Since the introduction of federal programs like Medicare and Medicaid, there has been little to no advancement in the government's assistance to alleviate the current situation, other than the passing of Obamacare, or the Patient Protection and Affordable Care Act (ACA). The ACA, passed by President Obama, helps expand Medicaid to "cover all citizens and legal U.S. residents with family incomes less than 133% of the federal poverty level" and subsidises small and medium-sized companies' employment insurance (Rosenbaum, 2020). The legislation was seen as revolutionary, especially to those traditionally shut out of the American medical system, such as the African-American and Latino American communities. Yet, many interest groups argued against some of the provisions, saying that it restricted consumer choice and insisted that market-based principles still should be the guiding principles of American healthcare (Sade, 2012).

Continuing the Obama era policies, President Biden signed the Inflation Reduction Act in 2022, which again attempts to limit the costs for Americans, yet its impact is limited. It expanded the power of Medicaid by allowing for some negotiated drug prices and caps on out-of-pocket fees (Politico, 2024). The Chamber of Commerce was suing and challenging the constitutionality of the program, and given the new administration's spending cuts, it is likely going to be repealed soon.

Beyond legislation directly impacting citizens coverage and access, there have also been measures to attempt to increase the transparency of the chargmasters, hoping that it would allow people to choose hospitals that better fit in their budgets (Fournier et.al, 2020). While it was well intentioned, the publishing of such lists online was rather surface level, as when people were experiencing emergencies they were not comparing prices of different hospitals, but rather trying to find the nearest one for help. The true issue is the need to have a fixed method of calculating the prices that appear on these chargemasters and have the actual prices of each procedure listed for those uninsured or out of their coverage (Fournier et. al, 2020).

Recommended Policies for A Path Forward

In order for the US American Healthcare system to truly develop to its full potential and lead to more significant innovation among the medical community, the following policies must be implemented:

1. **Changes to Insurance Company Denial Appeal Processes**

- Given the immense number and frequency of insurance denials, it may be surprising to learn that only 0.1% of cases are formally appealed, due to a various of reasons. One of the main reasons is that the appeal process is often tedious and it is ultimately up to your insurance company, not your medical professionals, to decide what is medically necessary for you, therefore deciding what is insured and what is not (Pollitz et. al, 2023). The process is purely bureaucratic and lacks the flexibility needed to address real life cases that go beyond the standard procedure, therefore the appeal process should be shortened and be able to include the expertise of medical officials into its considerations. Furthermore, insurance companies should not be able to deliberately deny claims from those who have filled more claims or appeals, to protect people from potential retribution.

2. **Private Insurance Companies Need to Collectively Bargain Charge Masters**

- The reason why the costs of procedures in countries where there are universal healthcare like Canada, the United Kingdom, and Taiwan is due to the fact that there is a government that collectively helps bargain prices with medical providers, giving them more power to negotiate down the prices. While universal healthcare is likely impossible, these private insurance companies should collectively bargain with American providers to help decrease prices, as when they individually bargain, then have less power to get better deals.

3. **Decreasing Cost of Pharmaceutical Drugs**

- Beyond the cap on insulin prices for Medicaid patients introduced under President Biden and then repealed by President Trump in 2025, there needs to be a substantial decrease in many of the drugs that are needed for survival. The fact the people with diabetes in the US were resorting to rationing insulin or driving to neighbour countries should have been

a key indicator showing the ridiculousness of the American healthcare system. There needs to be a limit on the amount of vital drugs can be upcharged in comparison to similar high-income nations, but with some leeway adjusting to America market prices.

4. **Limiting Private Healthcare Corporations Power in Washington**

- The abundance of money gained from private healthcare companies has ironically led to their greater consolidation of power and leverage over healthcare legislation. Currently, many politicians from both political parties are funded by large healthcare corporations, in return for favours such as voting against measure that attempt to restrict drug prices, which is why there have been no major healthcare reform since the end of World War 2. While this is largely unpreventable, there should be greater transparency in these funds and the activities of these healthcare lobby groups. I propose that for every dollar amount spent funding political campaigns or public interest groups to promoting their cause, there needs to be a match in that value that is used to fund research for better healthcare outcomes in the US. It is fine that they want to promote private healthcare, but they should hold up their end of the bargain which is greater innovation and efficiency, as the US falls behind on most metrics in comparison to other high-income nations.

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