US health care system benefits insurers, not patients or doctors

By Sheldon Jacobson

A cancer patient receives treatment in a Chicago hospital.
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Could this be the year when America starts to shift away from the employer-sponsored health insurance model?

To be sure, health care is an issue that concerns most people. Whether it is accessing care or paying for health care services, few people are free of the anxiety that comes when they or a loved one must undergo treatment for an acute life-threatening or debilitating chronic condition.

In spite of the $4 trillion spent in 2021 on health care in the United States, the highest per capita spending in the world, life expectancy in our nation continues to languish in comparison to other industrialized countries.

So what are the issues that demand discussion and resolution?

For many people, health insurance is tied to their employment. When they take on new employment, their health insurance coverage moves as well. This creates a patchwork of coverage that is susceptible to cracks during any transition. If there is a gap in employment, COBRA is available to provide coverage, at the person's own expense.

The Affordable Care Act also ensures that everyone can gain access to health insurance, with no limitations for preexisting conditions. The growth of the gig economy further highlights why health insurance must not depend on traditional employment. Untethering health care from employment is not only a good idea but also essential to expanding the footprint of people with health care security.

One solution is separating the delivery of health care service from the payment of these services. Such a separation is critical to resolving a lack of access to health care services and exposing such issues in our nation's health care system.

For most people, health care services are covered by health insurance. Health insurance companies are highly profitable. In 2020, they generated $31 billion in profit, an increase of more than 40% from 2019. In 2021, they earned a paltry $19 billion in profit. The upward trend returned in 2022, with the six most profitable health insurance companies earning more than $41 billion in profit.

The question is: Should a commodity that provides a public good like health care services be positioned to generate profits from such a public need?

One alternative is a single-payer system, much like Medicaid, Medicare and Veterans Affairs. This topic is a lightning rod for controversy. Some argue that the government is ill-equipped to provide health care services for the nation. Yet, a single-payer system does not mean that the government will provide services. It will only be the funnel through which health care services are paid. A single-payer system exists in 17 countries, providing models for how it can be achieved in the United States.

A second alternative is to establish and grow a network of not-for-profit health insurance companies. If health care providers work toward accepting coverage from only these entities, for-profit companies will eventually be phased out. The benefit of not-for-profit health insurance is that any excess income is used for the good of its constituents, not shareholders.

Such a solution represents a long-term vision, given that such a transition would be met with resistance by the for-profit health insurance industry, which lobbies and makes campaign contributions to maintain the status quo. Nonetheless, this direction demands attention and consideration given the current state of affairs.

The disconnect among health insurance, health care providers and patients has created an equilibrium that serves the best interests of health insurance companies, while placing patients and health care providers at the mercy of these companies. As middlemen, health insurance companies effectively control the flow of health care services to patients via prior authorizations. This means that health care providers are de facto working for health insurance companies, since they pay for the services provided.

There is some glimmer of hope for health care providers and patients. UnitedHealthcare's recent change in its prior authorization process is an implicit acknowledgment of this issue and a move in the right direction.

At the center of health care must be the patient. For health care to function in the best interest of patients, physicians and other health care professionals must be steering the ship. In the current environment, health insurance companies are in charge. This hurts patients, as they may not get the care they need and deserve. It hurts physicians and other health care professionals, as they are forced to spend time and resources fighting for their patients, and even to get paid for their services.

Plain and simple, the current system is functioning in the best interests of the health insurance industry.

When discussing health care in the U.S., the services provided need to be separated from the finances to pay for them. The financial component is overwhelming the service component. Until this is addressed, the current situation will continue — to the detriment of physicians, health care professionals and, most critically, patients, which we will all be at some point.

Sheldon Jacobson is a professor in computer science at the University of Illinois at Urbana-Champaign. A data scientist, he applies his expertise in data-driven, risk-based decision-making to evaluate and inform public policy.