‘Rationing by Inconvenience:’
How Insurers Keep Patients From Care

“If you think about someone who has high health insurance literacy, you should be imagining someone who is affluent or at least financially comfortable, educated, white, native English speaker and not elderly. So I basically just described myself, and even for me, there are times when I'm just like, ‘What is going on here? How do I fix this?’” Miranda Yaver, PhD.

What happens when you have health insurance, but still can't get the care you need?

Why do patients spend hours on hold, battle claim denials, and navigate endless paperwork just to access benefits they've already paid for?

And what does it say about our healthcare system when getting treatment depends not just on your medical needs, but on how much time, money, and persistence you have to fight for it?

Welcome to **Code WACK!,** where we break down how our healthcare system really works, what it means for you, and how we can make it better for everyone.

I'm your host, **Brenda Gazzar.**

(music)

Most of us think about health insurance in pretty simple terms.

You pay for coverage. You get sick. You get care.

But our guest today says that having insurance and actually being able to use it are often two very different things.

Miranda Yaver is an Assistant Professor of Health Policy and Management at the University of Pittsburgh and author of ***Coverage Denied: How Health Insurers Drive Inequality in the United States*.**

YAVER: "So one example that I'm thinking about is a mother who I interviewed about trying to get their daughter higher level behavioral health care, because they were struggling with severe depression, anxiety, suicidality, and they were running into a lot of insurance barriers.

"And what they were able to do was float just enough money to keep their daughter in treatment while they were fighting for coverage in hopes of reimbursement.

"And they were able to liquidate their inheritance and deplete their 401(k).

"And yes, it's lucky that they had those resources to begin with, and a lot of people don't.

"Economic privilege can not only give us more resources to just figure out the system in all of its complexity, but it can also buy us the flexibility to pay for the drug out of pocket while we yell at our insurance company instead of having a gap in care.

"Or facilitate our kid getting the care that they need now, and hope to figure out the insurance issues on the back end."

And that burden isn't just financial.

YAVER: "The amount of overwhelm in the moment about 'will I get this reimbursed or will I be able to get the care', I think that's a really potent part of this emotional overwhelm, the psychological toll.

"But I think that's actually just part of it because there's also this whole other layer of emotional overwhelm that goes beyond can I get this care.

"It actually extends to this broader trust in the system.

"'Am I worth this? Can I afford to continue to get this care? Because what if they deny the next thing? I don't know if I have it in me to keep fighting.'"

YAVER: “I talked with a lot of people who started to space out their treatments or forgo future care because they just didn't really feel that their insurance company or the system was going to be there for them.”

Yaver has a name for this.

YAVER: “That's why I call it ‘rationing by inconvenience’ because if you can withstand all of these collective pressures, you are probably actually going to get the care.

“But there's just all of these accumulated roadblocks that make it feel so much more insurmountable.

The more people Miranda talked to, the more she realized this wasn't just a patient story.

It was a physician story too.

YAVER: “One of the things by which I've been really struck and continue to be is the immense staffing requirement that is made necessary by all of this administration.

“So I talked with one physician at a major research hospital in Los Angeles who said, ‘we have five administrative support staff in my pulmonology office who are dedicated to dealing with prior [authorization issues. And then I step in if there's an issue so that I need to deal with a peer-to-peer request or appeal something,’ but they do all the front-end work.

“And if you figure that these administrative support staff are paid in the ballpark of [$60,000,] or [$65,000] a year, that's about a third of a million in salary alone, not including benefits, just for prior auth administration and related insurance paperwork.

“That is a hefty price tag for any research hospital.”

Five staff members just to deal with insurance paperwork.

That detail says a lot.

YAVER:

“And it is infeasible when you think about a rural community hospital where providers are just not going to have that staffing support and are going to be stretched much more thin.

“And then I certainly talked with a lot of physicians who described just really galling detail, just the kinds of runaround tactics.

“So, for example, getting asked to submit information about a patient that could have been requested just on the front end with the initial request, but at like 4:50 p.m. on a Friday, submitting the information Monday morning and then having it denied for lack of a timely response.

“And those kinds of things, and that harms both providers because they're stretched thin in dealing with all of this administration, and of course it trickles down to patients as well because once it gets denied then you have to deal with all these appeal processes.

By this point in our conversation, I found myself wondering….

If patients are struggling with the paperwork…

And doctors are struggling with the paperwork…

Maybe the paperwork isn't the side story. Maybe it's the story.

And now artificial intelligence is becoming a part of that story too.

YAVER: “Health insurers are overwhelmingly now using AI programs with which to bulk process claims and prior authorizations.

“And to be honest, there are ways in which this can accelerate the efficiency of insurance operations.

“If you can quickly and efficiently match a diagnosis code to a procedure code, then you can theoretically approve prescription drugs and imaging and those kinds of things much faster.

“You can schedule your appointment sooner, and that's all well and good.

“The problem, as I think any university professor who has seen AI-crafted submissions from students, is that these tools are evolving faster than regulatory oversight can keep up with, and they're not always quite there yet.”

“Unlike a student submitting something that has a hallucinated citation that will result in a slight deduction of points from an assignment, with healthcare the stakes are very very high.

Miranda points out that appeals succeed often enough to raise important questions about some of those initial decisions.

YAVER: “Overall, we see that about half of appeals are successful.

“But in the context of the litigation against some major insurers, Medicare Advantage plans, what the lawsuits alleged was reversal rates of 80 to 90% upon appeal.

“Now that doesn't mean it's an 80 to 90% error rate because patients' conditions could have changed, information submitted may have been incomplete, there could be various factors at work.

“But it does suggest a non-trivial error rate when 80 to 90% of appeals are successful, and so that raises eyebrows from my standpoint.”

The more we talked, the more it felt like all roads were leading to the same place.

The denials.

The appeals.

The prior authorizations.

The hours on hold.

The administrative staff.

All of it seemed connected to a bigger question:

How much of this complexity is actually necessary?

So I asked Miranda what she would build if she could start over.

YAVER:

“If I could wave a magic wand, I think single payer would be certainly a good way to go.

“It has the administrative simplicity that makes it a lot easier for patients and providers to navigate.”

It makes sense when you realize that almost every problem she described traced back to complexity.

The maze of rules.

The paperwork.

The appeals.

The uncertainty.

The need to become an amateur insurance expert while you're also trying to deal with a health crisis.

But Yaver is also a political scientist.

And she distinguishes between what she'd ideally like to see and what she thinks **is more likely to gain support.**

YAVER: “I don't think that readers of Coverage Denied would be shocked to know that I am not a big fan of privatization.

“But I think that the biggest problems that America faces are not from privatization in and of itself.

“It's that we have combined privatization with deregulation.

“Essentially, what we've done is put a lot of power in the hands of private actors, and then said, ‘Go forth, you do you.’

“But what Switzerland and the Netherlands both show is that you actually can house a lot of insurance delivery in private entities if you have heavy-handed government regulation over cost control, over insurance practices, so that patients have adequate protection.”

Before we wrapped up, I asked what people should do if they're facing insurance barriers right now.

YAVER:"If you are struggling with health insurance barriers, absolutely appeal.

"And even if you lose within your health insurer, *there's also an external independent medical review process that states set up and that it is worth pursuing.*

And despite everything she's documented, Yaver actually sees room for optimism.

YAVER:

"There aren't that many areas of health policy where there's actual bipartisan agreement about the problem and some of the solutions.

"But this is one of them, at least at the state level.

"Most of the state prior authorization reforms have passed with flying colors, whether unanimously or close to it.

"And so, when you look at KFF polling that shows that prior authorization is the biggest source of frustration for insured patients, members of Congress and state legislators-they're hearing this, and so I think that it's really telling that people at different levels of government are actually hearing the aggravation of patients as well as physicians, and this is even in the period of heightened polarization and gridlock. This is an area where we actually can move the needle."

And that brings me back to something Mirana said at the very beginning of our conversation.

YAVER:

"If you think about someone who has high health insurance literacy, you should be imagining someone who is affluent or at least financially comfortable, educated, white, native English speaker and not elderly. So I basically just described myself, and even for me, there are times when I'm just like, 'What is going on here? How do I fix this?

If navigating this system is difficult for someone with every advantage, what does that mean for everyone else?

That's really the question at the heart of Coverage Denied: How Health Insurers Drive Inequality in the United States.

And it's the question behind Yaver's phrase: rationing by inconvenience.

Because most of us think of rationing as somebody telling you no.

Her argument is that sometimes nobody has to say no.

Sometimes all you need is enough paperwork.

Enough delays.

Enough uncertainty.

Enough friction.

And eventually people stop trying.

That's not really a problem of medicine.

It's a problem of system design.

Which points to something healthcare reform advocates have known all along: If the system was designed that way, it can be redesigned too.

Thank you Miranda Yaver of the University of Pittsburg.

If you've enjoyed this code WACK episode, subscribe, leave a review and share it with a friend.

This podcast was powered by HEAL California, uplifting the voices of those fighting for healthcare reform around the country. I'm Brenda Gazar. Thanks for listening, and until next time, stay healthy.