

Avigail: Hi, I'm Avigail Oren.

Lisa: And I am Lisa Hernandez.

Avigail: And we are your hosts for Scholar Strategy Network's No Jargon. Every other week, we discuss an American policy problem with one of the nation's top researchers without jargon.

Lisa: Once again, it seems like we are in the middle of a healthcare fight in the U.S. It's giving very like 2010-ish vibes in the news right now.

Avigail: Yeah. It does feel like we've climbed into a time machine and shot back 15 years. We're recording this on November 17th and so we've just come to the end of this most recent government shutdown. And, you know, that alone feels like Groundhog Day at this point. The healthcare debate does seem like the gift that keeps on giving, except that, as our conversation today will show, it's more like taking.

Lisa: Yeah, absolutely. And there's definitely, with the give and take, when it comes to these policy conversations and debates, it is definitely at the cost of a lot of people's confusion when it comes to where, what kind of access do they have for healthcare options, at the moment? Are they gonna have to pay more? Will they still have government-funded care available, or partially funded care available? There's just so many questions up in the air as it comes to everyday people's healthcare options right now.

Avigail: And that's why I was really happy to talk to our guest for this episode who helped unpack this big, unwieldy issue. For this episode, I spoke to Miranda Yaver, an assistant professor of Health Policy and Management at the University of Pittsburgh and a healthcare fellow at the Roosevelt Institute. Her work looks at health and health insurance gaps in the U.S., focusing on how administrative burdens contribute to disparities across both public and private insurance.

Here's our conversation.

Avigail: Professor Yaver, welcome to No Jargon.

Miranda: Thanks so much for having me.

Avigail: So we're recording this episode on November 17th, and the country just went through the longest government shutdown in history, at a total of 43 days. Can you help set the stage for us? What were the main drivers of this shutdown, and what have been the biggest consequences for healthcare in the U.S.?

Miranda: So at the heart of the shutdown negotiations was the extension of the enhanced subsidies under the Affordable Care Act. So coming out of the worst of the Covid pandemic with the Biden administration, we get the American Rescue Plan Act and then later the Inflation Reduction Act. And what both of these laws did was they provided additional subsidy support to offset the cost of premiums for people who made up to 400% of the federal poverty level. So essentially, doing a little bit extra to make health insurance affordable. And these subsidies were really impactful, and actually brought down the cost of health insurance by about 44%, which is really dramatic. The catch is that these enhanced subsidies are set to expire at the end of this calendar year.

And so then, with this new budget, there was a lot of contestation over should these subsidies be extended. There was then a coalition of some Republicans who were seeking to maybe extend the subsidies one extra year to get through the midterm elections. But, there was a really heated battle. And what has actually come about is that eight Senate Democrats sided with the Republicans to reopen the government through January 30th while the Democrats had been trying to extract concessions from the Republicans to extend these subsidies to promote healthcare affordability. This ended up, essentially, being resolved with the promise of a December vote.

But the reality is that open enrollment is going on right this very minute. People are selecting their health plans, and absent these enhanced subsidies, people's marketplace premiums are essentially doubling. And for someone who is working and having and has kids and maybe lives in a more expensive area, doubling the cost of the monthly premium is a heavy lift.

Avigail: Yeah. Can you actually walk us through how the expiration of the enhanced marketplace subsidies will lead to premium increases, and how will it affect Americans who rely on government assistance and even those who don't?

Miranda: You might have noticed that I said that the enhanced subsidies brought down the cost of health coverage by about 44%. But the premiums are now doubling, and the fact is that it's sort of a lot of moving parts going on right now.

So when health insurance becomes more affordable, such as through these enhanced subsidies, then younger and healthier people might see more value in becoming insured. Because they're not gonna be paying an exorbitant amount for insurance when they're not gonna be as heavy utilizers. And when we have younger and healthier people paying premiums participating in the marketplace, this can offset the costs of covering older adults, sicker adults, people who are utilizing their healthcare a lot more.

And so when we take away this enhanced assistance, then what the expectation is is that these younger and healthier people are going well, I'm only seeing my primary care doctor and getting a couple of less expensive drugs or a couple basic screenings. I don't want to pay this exorbitant amount of money every month I'm gonna drop out.

What that means is that the risk pool, that is to say, the insured population that's left over is on average, sicker, older, and therefore costlier to insure. And so then health insurers are recalibrating what it makes sense for them to set the premiums at. So part of the premium increases are directly attributable to the subsidies going, the enhanced subsidies not being in effect anymore, and part of it is essentially the guesswork about who is going to drop out, which is going to then make it just a more expensive enterprise to be participating in these markets.

Avigail: And that's the case for both Americans who are relying on assistance and those who don't.

Miranda: So this is for the Affordable Care Act marketplace, but we are also seeing employer-sponsored insurance plans going up. But it's not nearly the rate

that we're seeing on the marketplace, where we're seeing these really striking policy shifts. In the employer-sponsored marketplace, we're seeing premiums going up in the neighborhood of 6%, which is in line with the previous year, and that is really less the result of policies related to governmental support and more just the reality that healthcare delivery in the United States is notably expensive. Because we make a lot of choices in the United States to house health insurance delivery, healthcare delivery in for-profit institutions, they have to essentially make up the difference by raising our premiums.

And then, of course, the other big area where we're seeing shifts in health insurance access is with the Medicaid cuts under the so-called One Big Beautiful Bill Act.

Avigail: I wanna ask you about the population that is tending to purchase ACA coverage or marketplace coverage. What's the current profile of those consumers? And is there anything about that population that is making them more vulnerable or extra affected by these changes?

Miranda: So we obviously in the United States have made a number of choices to tie health insurance to employment, but not everyone works in a job that offers employee health benefits. And so when we look at who is in the marketplace, these are typically people who make too much money for Medicaid.

And the Medicaid cutoff is gonna vary depending on whether you're in a state that chose to expand Medicaid, which 40 states plus DC have. Or whether you're in a state that did not expand Medicaid. But basically if you are making too much money for Medicaid and you are in a job that doesn't have health insurance benefits, then the marketplace is the natural place to purchase insurance.

And these were people who previously didn't really have any options. Which is why going into the enactment of the ACA, about 50 million Americans were uninsured. So we can think about a number of different people who might be in these plans. And it is actually a fairly economically diverse population.

So, for example, there is, of course, a lot of hourly workers. Where you might be working at a wage that's going to take you beyond the Medicaid threshold, but still

within the realm of being able to get a whole lot of enhanced subsidy assistance through the marketplace. But there's also people who might be working as independent contractors, writers, where maybe you're self-employed and therefore don't have, you know, a big HR office through which to enroll in benefits.

The enhanced assistance went up to 400% of the federal poverty level. And the reason why this was such a game changer is because for people who were making just a little too much to be on Medicaid, so let's just say hypothetically \$23,000 a year, they could get a marketplace plan for next to nothing. And this is really critical because if you are making that much, you probably don't have much in the way of disposable income. You're probably focused a lot more on rent and basic food necessities. But the enhanced subsidy has made insurance possible for these populations.

But we also know that helping the middle class is also really critical because, too often in America, the middle class can get squeezed. Where you're making too much to enjoy government assistance and not enough to be able to comfortably get comprehensive health coverage. And so this is also a population that is at risk of not being able to have affordable health coverage.

One thing that may happen is that people become uninsured. Another thing that may happen is that they opt for lower quality health plans so that they're not uninsured, but they might be underinsured, meaning that they have a high deductible so that they're covered if something catastrophic happens. Or, you know, they need a surgery or a really exorbitant test that they just cannot avoid. But from a day-to-day level, they may be insufficiently protected.

Avigail: So I wanna turn back to Medicaid. You just alluded to the fact that it was heavily impacted by the Republicans' budget bill this summer. Can you briefly remind our listeners just what happened with Medicaid and what the effect of those changes will be?

Miranda: The One Big Beautiful Bill act enacted about a trillion dollars in Medicaid cuts. This was historic. And the Medicaid cuts came in a number of

different ways. Their rollout is staggered over a relatively long time horizon. So, it was relatively crafty, deferring a lot of the implementation until after the midterms.

So one of the things that we saw was just cuts to funding. There is less money to go around to support the Medicaid program, on which one in five Americans rely. And some other really key facts about Medicaid, it covers 41% of births in America and it covers a little over 60% of nursing home care. And so when we think about nursing home care and pregnancy, these are really critical points in our life when we need that protection. And it covers a whole lot of children and it offers comprehensive healthcare to America's lower-income individuals.

So right now, not only is there less money to go around, but the BBB really, provided this interesting, unusual departure from what we typically see in healthcare with respect to Medicaid, which is federalism. So Medicaid is a federal-state partnership program, and states have historically been able to submit waivers to be able to adapt their Medicaid plans in ways that make sense for them. And so there, there's an expression that we sometimes use, which is when you've seen one Medicaid program, you've seen one Medicaid program.

But what the BBB does is it essentially strong-arms states into imposing new restrictions even with the state's own funds. So for example, what states are now going to have to do is they're gonna have to impose up to \$35 cost-sharing for health services to Medicaid recipients. \$35 to see a doctor. When you are making \$20,000 a year, that is prohibitively expensive for this population. For context, that is more than what I, a faculty member at the University of Pittsburgh, pay to see a doctor.

And so that is just one way in which the legislation imposes new constraints on the Medicaid program that will not only result in many people being uninsured. But even among the insured, they'll have a harder time accessing health services.

The other big reform that the BBB imposed was a national Medicaid work requirement. Now Arkansas in 2018 imposed the nation's first Medicaid work requirement. And so we were able to see how this played out in this one state, in the single state case. And what ultimately happened was that a lot of people had

never heard about the requirements. If they had, they didn't know it applied to them. And so 18,000 people in Arkansas ended up losing their Medicaid coverage. And it wasn't because they were not working. It was because they fell through the cracks amid the administrative burdens of documenting that they were working.

So 92% of Medicaid recipients are either working or would have an approved exemption, such as caregiving or being disabled. Now, it's not entirely clear what is going to count as disabled. Do you have to be on SSI, or do you just have to have a physician attest to your medical frailty? There are still some questions that need to be resolved.

In any case, when we see a number like 92% of Medicaid recipients working or being exempt, we might think, this probably won't be a problem. They're already working, they just need to fill out a form. But the challenge is that the devil's in the details when it comes to implementation and if the documentation process is really onerous or the program requirements aren't very visible, so people have a hard time figuring them out, many people are going to lose Medicaid coverage because of the administrative burden and not due to failure to work.

And what we also know is that administrative burdens tend to be most acutely felt by marginalized populations. Obviously Medicaid is directed at lower-income people, but we can also think about race and ethnicity, language, minority status, educational attainment, and so forth.

Avigail: So we've talked a lot about the effect on the consumer side. Can you talk a little bit about the provider side or the healthcare sector as a whole? How these policy shifts are gonna have ripple effects.

Miranda: One of the big challenges that America faces right now is that a lot of hospitals are operating in the red. They are struggling to stay afloat, especially in America's rural communities. These are communities that tend to have more Medicaid reliance. And when we see that as people become uninsured, their healthcare needs don't go away. But they might wait and wait and wait until they can't avoid going to the emergency department, which is an exceedingly expensive

place in which to get medical care. And then they might get a big medical bill that they cannot afford.

And so there are some hospitals that may have charity care programs. They will say based on sort of a sliding scale, you make X amount annually, so you'll be responsible for 30% of your bill or something to that effect. But we also know that that hospitals ultimately end up taking on a lot of uncompensated care when there are more people in a community who are uninsured.

So this is really expected to lead to a lot of rural hospital closures in America. For context, I'm in Pennsylvania. Pennsylvania has a large rural population. We have Pittsburgh where I am on one side of the state and Philly on the other. And there are a lot of rural communities in between. Seventeen rural hospitals in Pennsylvania are in a difficult financial position, and nine are at risk of immediate closure, and the expectation is that these Medicaid cuts may be the final nail in the coffin.

And so what does that mean? Well, one thing that this can mean is that people, patients end up having much longer driving times to receive medical care. When a rural hospital closes, the average driving time increases from 20 to 40 miles, depending on what type of medical care you need. If you just need stitches, it's not the end of the world. But if you're talking about a heart attack or stroke or pregnancy complication, that could be life or death.

We also know that physicians are going to get displaced and have a harder time finding work or finding work that is feasible. They may have to relocate, and then that's only going to exacerbate physician workforce shortages in certain communities. This is going to lead to broader unemployment in these communities.

Hospitals are often the largest employers in rural or semi-rural communities. And so we're not just talking about physicians, but we're thinking about lab techs and nurses and administrative staff and the whole team that works together to provide care to these communities. And so this is something that is broadly destabilizing for both patients and healthcare workers alike, and is ultimately going to undercut the economies of these communities.

Avigail: I wanna shift gears and talk about your forthcoming book, which is called Coverage Denied. Can you tell me a little bit about what inspired you to write this book?

Miranda: So I have a little bit of an unusual professional trajectory. I'm trained as a political scientist. I was teaching at visiting faculty positions in political science departments. But I'd always been interested in health policy. It was not a good time to study health policy. When I was in grad school, the ACA had just been enacted. It was getting dragged into court. I was not going to touch that. But I was really interested. I was squeezing it into my classes and I just decided, you know, I want to focus more on the health policy space, but needed to get some extra training. So I actually did a later postdoc in health policy and I was spending the first couple months reading and trying to figure out where the field was and how to best to leverage my expertise.

And I was in a new city setting up new providers, new prior authorizations. And everything was getting denied, even, you know, a one-time \$400 test that was clearly indicated. So not just high-cost care. And I'd experienced this before, but not on this scale, and I was overwhelmed and crying. I was thinking, oh my gosh, I'm supposed to be doing health policy research and just on the phone with my insurance company.

And then I realized: I am a white, native English speaker from the United States, have a PhD from Columbia, was working in a public health school, had time in the middle of my day to stay on hold with my insurance company to sort things out. If I was struggling, what would my neighbor do?

And then I really zeroed in on these two themes of administrative burden and inequity in accessing healthcare. Something that had really struck me was that in the 2000s and 2010s, so much of the discussion of healthcare and really in the 1990s as well, was about expanding access, expanding the number of covered individuals. But what had gotten so much less attention, except for the late 1990s when Congress tried to pass a patient's bill of rights, what had gotten so much less attention was fixing insurance for the covered population.

And a lot of times, you know, if you're pretty healthy and you don't require costly treatments, you may not run into insurance barriers. But for anyone who is on a more expensive prescription drug, they probably have experienced one too many times the feeling of going to the pharmacy and realizing that they can't get their drug because there's going to be a long, drawn-out prior authorization process. That was the story that I wanted to tell through a combination of survey evidence, administrative data, and semi-structured interviews.

Avigail: So I want to use the topic of your book to kind of back up a little bit and look at the history of health insurance in the United States 'cause you just beautifully summed up what the preoccupations have been over the last 25, 35 years. It was not a given that we were gonna have a private insurance system in this country. That is something that was historically contingent, that healthcare providers had a big influence on. And so I'm wondering if you could talk a little bit about what it means that we have a mostly private health insurance marketplace in the United States and how that has resulted in this coverage denial situation problem.

Miranda: We start to see private insurance come onto the map in 1929. Not a great economic year for the United States. It's Blue Cross, and it offers about three weeks of hospital care for teachers. And then 10 years later, we get Blue Shield plans offering some coverage for physician services.

And then we have World War II, and it's during this time that we really see employer-sponsored insurance take off. And it's fundamentally because with wage controls amid wartime, employers couldn't entice new workers with higher salaries. And so what they did was they relied on these fringe benefits, namely health insurance.

Then we see Harry Truman ascend to the presidency and he makes it his commitment to campaign for national health insurance, which was met with stark opposition. Namely from the American Medical Association, which was very concerned about socialized medicine, which was an effective talking point going into the Red Scare period of America.

We end up, eventually, getting Medicare and Medicaid in 1965 under Lyndon Johnson's Great Society. And this was a huge expansion of health insurance for two critical populations, the indigent and the elderly. And this was rightly celebrated, but then there were understandably some new concerns about runaway healthcare costs. How are we going to pay for all of this? And the amount of money that was spent on these programs ended up being quite a lot.

And so then we start having these early conversations about, okay, how can we reign in spending? Well, one thing we can do is we can start doing utilization review, which is what prior authorization essentially is. Now, initially this was very, very limited in scope, such as certifying hospital lengths of stay.

As we continue to see these concerns about cost containment, we start to see the explosion of private health insurance. We see the Health Maintenance Organization Act enacted in 1973. We then see the creation of preferred provider organizations or PPOs a little bit later. And then in the 1990s, we have this explosion of managed care, namely with the Balanced Budget Act of 1997, where we see Medicare Advantage come onto the map.

We see more privatization of Medicaid. And in this growth of managed care, let's say private health insurance, we have these competing objectives. On the one hand, yes, we're in the business of health insurance delivery, but these are companies that have fiduciary responsibilities to shareholders.

And so we also see your concerns about not just cost containment for profit and maximization. Alongside all of this is the growing cost of care associated with medical innovation, newer drug development that does a really good job but also comes with a price tag. And so now basically, whenever we're prescribed higher cost treatments, whether that be a prescription drug, whether that be high-tech imaging, we can pretty much expect that there will be a prior authorization.

While most prior authorizations are approved, they do operate as a key vehicle for coverage denials. And what I find in the book is that these denials then cause all of these administrative burdens. Because once we get denied, then there's an appeal

process. And so a denial is not a final denial, but we're not all very well equipped to navigate those appeals.

Avigail: Yeah. And are there any inequities in who is and is not appealing?

Miranda: So one of the interesting things is that people who are from marginalized backgrounds are not necessarily more likely to be denied, but they're more likely to feel it much more acutely. So I find that lower-income patients are significantly less likely to appeal.

Another core finding that I had in the book was that people tend to understandably, I think, undervalue appealing. So one thing I asked every survey respondent was, how often do you think that people win insurance appeals? In truth, it's about a coin flip. You win about half the time if you're appealing, which is not bad.

But a lot of people think, well, I'm just one person. How could I possibly go up against UnitedHealthcare or Cigna or Elevance? And so about half of the respondents in my survey thought people won 20% of the time or less, and those people overwhelmingly did not appeal their own denials. And so people who tended to undervalue appealing, but also just people who are lower income, tend not to appeal as much.

And then when looking at who wins these appeals, people who were Black or Hispanic Medicaid patients, and sicker patients tend not to win as much. And in that sense, it's really understandable because navigating an insurance appeal process would be difficult on a good day. And we're generally not having our best day when we're dealing with this.

And so when we're in worse physical or mental health, all of these processes are just going to feel more laborious, which may not set us up for success.

Avigail: So in your book, you do outline some policy suggestions that you think would make the system more functional and more fair. Can you highlight a few of them for us?

Miranda: So one of the things that I put forward in the book is that it might be advantageous to shift from a prior authorization model to an audit-based model. We can't have entirely unchecked prescribing. We do not have an infinite amount of resources that we can divert toward healthcare, and there is some over-prescribing.

And we want to guard against that because not only is it costly, but it may not be good for the patient. Medications have side effects. For example, tests might have radioactive exposure, so we do want to guard against overutilization. The question is, what is the best way to do that?

What I argue is that shifting to an audit based framework that is just say auditing outliers and prescribing. Then potentially doing random audits of everyone else would essentially help us to identify the quote-unquote bad actors, ensure that people understand that their prescribing behavior may be overseen, and that could theoretically operate as a meaningful check.

And then maybe prior authorization can be a penalty for being an outlier as opposed to the default because even if prior authorization is guarding against over-prescribing, and I do think this is an open question, we do have to think about the trade off, which is that it's causing administrative burdens for both patients and physicians who have to devote immense staffing and time resources toward this. And, there's very little question why some have characterized prior authorization as a vehicle for physician burnout. So I think an audit-based model would be superior.

And then we can also look to a number of other ways that both Congress and the states have sought to better streamline and otherwise improve the efficiency of prior authorization. So Congress came close to passing and ensuring Seniors' Timely Access to Care Act in 2022, it passed by a voice vote in the House, and then died in the Senate as so many things do. And this would have moved more prior authorization or the remaining prior authorization electronic, which would sort of speeds up the efficiency and it would've narrowed the time window within which insurers had to render decisions. That wouldn't make it less likely you'd be

denied, but it might reduce the period where you're in limbo and wondering, do we have to move on to Plan B, where the patient might be untreated in the meantime.

And some states have enacted laws doing things like regulating the qualifications of reviewing physicians because, spoiler alert, when your physician hops on a peer-to-peer with your insurance company, it might not be a physician in the appropriate specialty. So I interviewed patients whose rare ENT surgery was denied by a gynecologist or whose rare neurological condition treatment was denied by a family medicine physician who would have no reason to keep up with the latest biologics. They would almost assuredly sent the referral.

And so there are things that can be done at the state level. That challenge is that there is this really, really big complicated law on which I'm writing my next book, called the Employee Retirement Income Security Act, also known as ERISA. ERISA does a number of different things that can undercut healthcare access. But one of the big ones is that it preempts state laws that relate to the majority of employer-sponsored insurance.

And so what that essentially means, and so this applies to what's referred to as self-insured health plans, which were very uncommon in the 1970s when this law was passed. Two-thirds of covered workers are in these plans. So what this effectively means is that anything that New York or Massachusetts or Pennsylvania wants to do to improve health insurance access by streamlining prior authorization and promoting health insurance equity, it's not gonna touch the majority of employer-sponsored insurance. And that's a problem because that is the dominant insurance model in the United States.

So something that I also call for is revisiting a National Patient's Bill of Rights, which Congress sought to pass in the late 1990s but which encountered a number of hurdles, including concerns about frivolous lawsuits, concerns about premiums increasing, and ultimately the Clinton impeachment.

Avigail: So we began this conversation talking about, you know, a government shutdown and all of this. So about the ACA, how do you feel about the potential for reform or the revival of a Patient's Bill of Rights right now?

Miranda: Oh, not at all optimistic whatsoever. Yeah, this, this would definitely be a few years down the line territory. One thing that I think is also worth noting, just to emphasize how far we are from that, is that while traditional Medicare has historically had very sparing reliance on prior authorization, the Centers for Medicare and Medicaid Services announced over the summer that it is launching a pilot program to introduce new prior authorization requirements for the traditional Medicare population.

Instead of going in the direction of streamlining things and reducing administrative burden, what we're actually doing is going exactly the other way. Introducing new burden for a population that may have particular challenges navigating insurance complexities, because seniors tend to have somewhat lower health literacy and greater health needs, meaning that the stakes are even higher. And this could be a recipe for disaster.

Avigail: Is there anything, you know, any steps forward that we are taking in the healthcare sector right now that we can celebrate?

Miranda: Oh, let me think....

Avigail: Let me ask you this question instead: So if you could send one message to policymakers or to the public about this moment in American healthcare, what would it be?

Miranda: Something that I think is worth emphasizing is that prior authorization actually has a lot of bipartisan appetite for reform. So something we are seeing some states passing laws to improve access to healthcare through these mechanisms, and they're garnering unanimous or near-unanimous support.

So even though we're in this incredibly fraught political climate when it comes to the ACA and Medicaid, and to an extent Medicare. When we look at what's going on in the states, whether we're looking at red states, blue states, purple states, we're getting a lot of unanimity in efforts to reduce these burdens.

Maybe there is a possibility that this will reach the federal level. We did see a voice vote for the Insuring Seniors Timely Access to Care Act in 2022 and so it doesn't seem impossible. And now, of course, at the state level, there are limitations because some policies just need to be done at the federal level, but at least we're getting some glimpses of ways to improve access to care and ways to build diverse coalitions.

Whether thinking about how California has passed legislation to better oversee the role of AI in processing prior authorizations and claims or other state efforts to pare back prior authorization burdens, at least there is some potential. I think it's just a question of how long we'll be waiting to see that at the national scale.

Avigail: Not impossible, and some potential. I will take it. That sounds great.

Miranda: In 2025, I think that's the best we can hope for.

Avigail: Well, Professor Yaver, thank you so much for coming on No Jargon.

Miranda: Thank you so much. It's been a pleasure.

Avigail: And thanks for listening. For more on Professor Yaver's work, check out our show notes at scholars.org/no-jargon. No Jargon is the podcast of the Scholars Strategy Network, a nationwide organization that connects journalists, policymakers, and civic leaders with America's top researchers to improve policy and strengthen democracy.

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