

**Mini Review**

# Patients suffer when healthcare stocks rise

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When a stock price rises or has a better P/E ratio, this is generally considered a measure of success. Is this true for health insurance stocks? Stock holders certainly are happy, but what about the purchasers of the carriers' policies? Are patients smiling when the stock price goes up?

The primary function of any healthcare system is *not* to save money or to insure people. It is to facilitate timely access to needed care. Having an insurance policy, whether private or government-supplied, is considered the key to a doctor's office [1]. One might surmise that when an insurance *seller* does well, so does the insurance *buyer*.

Is there a relationship between the financial condition of companies that sell health insurance and the people who buy their policies?

**Financial data**

The ten-year period of 2007-2017 was chosen as it spans a time before the Affordable Care Act was passed in 2010 to three years after the ACA was implemented. Market changes should be in part attributable to the ACA.

The seven companies listed in table 1 represent major sellers of health insurance. Together, they cover more than 128 million Americans, including more than 4 million with Medicare supplemental policies.

Over the ten years, stock prices rose 157% to 635 % (Table 1). During the same period, the S&P 50 increased 82%. The one-year forward price/earnings (P/E) in 2007 ranged

from 8.27x to 16.44x. By 2017, the P/E ratio has increased in every case, from 17.45x to 23.3x. The one-year *relative* P/E ratio also increased in five out of seven stocks and decreased slightly in two.

**Access to care**

Two useful metrics of access to health care are wait time to see a primary physician and the percentage of physicians willing to accept Medicaid patients. In 2018, 74.8 million Americans were enrolled in Medicaid. People who have no regular primary doctor—whether the patient is privately insured, covered by Medicaid, or uninsured—tend to forego routine or preventative care and depend on Emergency rooms for care [2].

In 2007, 74% of U.S. physicians accepted new Medicaid patients into their practices. That percentage decreased to 55% ten years later [3]. From 2007 to 2017, due largely

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**Table 1:** Sellers of Health Insurance.

Company	Stock Price (12/31/yr)			Americans covered by company policies*
	2007	2017	Change	
Anthem	\$ 87.73	\$ 225.01	↑ 157%	40.8 million
Cigna	\$ 53.73	\$ 203.09	↑ 278%	11 million
Humana	\$ 75.31	\$ 248.07	↑ 229%	13 million
UnitedHealthcare	\$ 58.20	\$ 220.46	↑ 279%	41.6 million
Centene	\$ 6.86	\$ 50.44	↑ 635%	14 million
Molina	\$ 25.80	\$ 76.68	↑ 197%	3.5 million
Wellcare Health	\$ 42.41	\$ 201.11	↑ 374%	4.4 million
S&P 50	\$ 1,468.36	\$ 2,673.61	↑ 82%	N/A

Yr = year. S&P 50 = Standard and Poor's top 50 companies. (\*) published enrollment numbers are from different years, 2015 to 2019.



to Medicaid expansion under the Affordable Care Act, the number of uninsured Americans declined from 47.5 million to 39.9 million.

The maximum wait time to see a primary care physician was chosen rather than the average wait time because medicine is practiced on individuals, not on populations. The patient who waits the longest is most likely to suffer harm from the delay. The maximum wait time in 2007 was 99.6 days and increased to 175.7 days [4].

The change in stock prices and decline in availability of care are not merely coincidental. They are statistically related. Pearson's chi square test ( $\chi^2=24.5582$ ) indicates a strong correlation,  $p < 0.0001$ .

## Conclusion and recommendation

A host of factors influence the price of a stock including general economic conditions, competition, leadership and capitalization of companies, and the regulatory environment. However, all factors culminate in the public perception of future earnings, which affects the price people are willing to pay for a stock.

Evidence suggests a link between a rise in prices of insurance stocks and a decline in patients' access to care. Health insurance sellers increase profits by (a) not paying for patient care, and/or (b) delaying payments, so the retained earnings can be invested. This "three D" strategy—delay, defer or deny care—generates profits and drives the stock price upward while closing the door to the doctor's office [5].

Reduction in availability of care is an adverse impact—a symptom of healthcare dysfunction. To reverse it, one must identify and treat the root cause, which is the system, not the individuals.

Third-party payment structure is the root cause—it misaligns the incentives by rewarding the outcome consumers *don't* want, less care, instead of incentivizing the desired outcome, access to medical care [6].

To realign the incentives requires reconnecting buyer (patient) with seller (provider) so the buyer pays the seller directly rather than the third party, government or insurance. When buyers spend their own money instead of OPM (other people's money), they automatically align the incentives to get what they want: care. When the third party pays, it gets what it wants: profit for insurance carriers and power for the federal government.

Reconnection of buyer and seller is a market-based approach and the antithesis of government-controlled single payer or Medicare-for-All. For those who would claim that Americans cannot afford to pay for their care, facts suggest otherwise. In 2018, the average American family spent \$28,166 on healthcare costs representing more than 40 percent of median gross income [7,8].

Market-based financing of healthcare would be less expensive and could provide timelier care than the system we currently have or changes in healthcare being planned by Washington [5,9].

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