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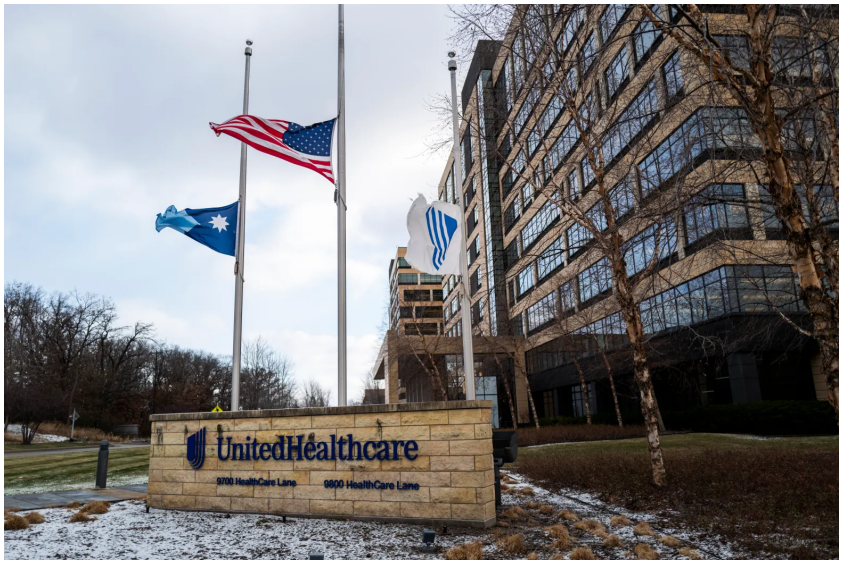
OPINION > COMMENTARY

Michael L. Millenson: Abuses by doctors and hospitals led to health insurers' clout over coverage



Flags fly at half-staff outside UnitedHealthcare headquarters in Minnetonka, Minnesota, on Dec. 4, 2024. (Stephen Maturen/Getty)

By MICHAEL L. MILLENSON
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The outburst of complaints about dubious practices by health insurers, spurred by the horrifying killing of UnitedHealthcare Chief Executive Officer Brian Thompson, has overlooked the important roots of insurer power. The industry's clout was conferred on it by employers and government in an attempt to counter decades of financial and clinical abuses by doctors and hospitals.

I've delved deeply into the history of health care and also spent decades as a consultant and activist, and it's frustrating how the way many (though not all) insurers have wielded their power has left patients still unprotected. Nonetheless, in addition to focusing on insurer iniquities, we also need to bring physicians and hospitals into the examination room.

As the late Chicago Archbishop Joseph Cardinal Bernardin bluntly told American Medical Association delegates at a meeting in 1995, physicians "must accept a major share of the responsibility for where you are today."

Some conservative groups believe that restricting third-party payment and restoring the direct economic relationship between patients and doctors will cure U.S. health care ills. However, in the 1950s, when relatively few Americans had health insurance, what actually occurred was very different.

With insurer or government oversight absent, provider freedom spawned assembly-line tonsillectomies, a high rate of unneeded hysterectomies and enough other outrages that one popular magazine suggested “some doctors should be in jail.” Public dissatisfaction with doctors’ fees was reflected in a 1959 cartoon in The New Yorker showing a middle-aged physician making a house call to an elderly matron. As she glares from her bed, the doctor opens his black bag and wads of money pop out. “Pshaw! I grabbed the wrong bag,” the doctor exclaims.

Medicare took effect in 1966, with the federal government allowing doctors to charge whatever they deemed “reasonable” and police themselves. Within five years, a Senate hearing highlighted “ruthless providers of health services,” such as the general practitioner who billed Medicare $58,000 for home visits to 49 patients. Separately, a House report concluded the government was paying for 2.4 million unnecessary surgeries annually.

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Soaring hospital use was accompanied by soaring prices. As a former executive of a nonprofit hospital told me years later, since “there was no limit on reimbursement,” he instructed his team to “get the rate up as high as we can.”’

That's when employers and government, desperate to excise the excesses of a system lacking effective checks and balances, turned to health insurers and other intermediaries to not just pay bills, but to also review the appropriateness of care and cost. Over time, that review power has steadily grown. To understand why, here's a sampling of headlines from The New York Times that highlight how repeated evidence in the medical literature of overuse of an expensive surgical procedure completely failed to get doctors and hospitals to stop it.

- "Long hospital stay for heart patients called unnecessary" (1973)
- "Heart bypasses are often unnecessary, study says" (1977)
- "44% of heart bypass surgery is unneeded" (1988)
- "Tens of thousands of patients may not need open-heart surgery" (2019)
- "The heart surgery that isn't as safe for older women" (2024)

The 2024 article notes that open-heart surgery is still "the most common cardiac procedure."

Not all health insurers are the same, any more than all doctors and hospitals. There are behemoth publicly held firms and local, national and regional nonprofits. With varying degrees of success, all have sometimes controlled costs and improved quality of care. But the positive impact of the industry must be weighed against the human and financial costs of what clinician surveys report is a steady increase in "delay and deny."

Doctors and patients alike have been infuriated by the kind of callousness that X user Ryan Solsten recently described in a post that has received more than 5 million views. Solsten says that as he was sitting with his father in the hospital after surgery to repair a heart valve, his father's "doctor walked in and said his insurance company tried to deny his care yesterday, she told them it was too late, he was already in surgery."

Similar experiences are not uncommon. In a 2023 survey by the Commonwealth Fund, about one-sixth of respondents said an insurer had denied coverage of care recommended by a doctor, and in nearly half those cases, the individual's health had worsened as a result.

While criticism of publicly held insurers has been particularly pointed, you don't have to be "for-profit" to be "for profit." U.S. hospital prices are the world's highest, and a recent KFF Health News investigation found hundreds of hospitals suing patients or threatening their credit rating if they couldn't pay up. Those taking aggressive action included "public university systems, leading academic institutions, small community hospitals, for-profit chains and nonprofit Catholic systems."

A separate KFF Health News examination of physician upcoding found that minor procedures such as removing a splinter or treating a wart are increasingly being billed as a "surgery" costing hundreds of dollars. Health insurers, one expert said, "should be reviewing" the bogus bills, but the small amounts give them little incentive to do so.

There are no simple villains or heroes in U.S. health care — and that includes us, the public, a topic for another time. But for now, the pressing question is how to curb the unhealthy practices harming millions of Americans.

The most important step is transparency. Information on provider pricing is starting to be available thanks to regulatory mandates, but quality information is woefully sparse and routinely a couple of years old or more. The real crisis of trust, though, centers on health insurers. Assuaging often-justified anger requires much more public disclosure, not the same old public relations.

For instance, insurers could not only provide data on the rate of claims denials, but they also could set tough industry standards for rapidity of response and clarity in appropriate detail for members and clinicians alike when a denial does occur. And if a big part of their mission is financial protection, they need to be as detail-minded about protecting members' pocketbooks from unjustified provider charges as they are about protecting their own earnings.

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In a statement to The Washington Post, AHIP, the national association of health insurers, asserted that "plans are working to protect patients from the full impact of rising costs while connecting them to care that is safe, evidence-based and coordinated."

That's certainly what they're supposed to do. Now would be the time to prove they do it.

Michael Millenson, a former Chicago Tribune reporter, is the author of "Demanding Medical Excellence: Doctors and Accountability in the Information Age" and president of Health Quality Advisors.

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