The New York Times

February 16, 2007

OP-ED COLUMNIST

The Health Care Racket

By PAUL KRUGMAN

Is the health insurance business a racket? Yes, literally — or so say two New York hospitals, which have filed a racketeering lawsuit against UnitedHealth Group and several of its affiliates.

I don't know how the case will turn out. But whatever happens in court, the lawsuit illustrates perfectly the dysfunctional nature of our health insurance system, a system in which resources that could have been used to pay for medical care are instead wasted in a zero-sum struggle over who ends up with the bill.

The two hospitals accuse UnitedHealth of operating a "rogue business plan" designed to avoid paying clients' medical bills. For example, the suit alleges that patients were falsely told that Flushing Hospital was "not a network provider" so UnitedHealth did not pay the full network rate. UnitedHealth has already settled charges of misleading clients about providers' status brought by New York's attorney general: the company paid restitution to plan members, while attributing the problem to computer errors.

The legal outcome will presumably turn on whether there was deception as well as denial — on whether it can be proved that UnitedHealth deliberately misled plan members. But it's a fact that insurers spend a lot of money looking for ways to reject insurance claims. And health care providers, in turn, spend billions on "denial management," employing specialist firms — including Ingenix, a subsidiary of, yes, UnitedHealth — to fight the insurers.

So it's an arms race between insurers, who deploy software and manpower trying to find claims they can reject, and doctors and hospitals, who deploy their own forces in an effort to outsmart or challenge the insurers. And the cost of this arms race ends up being borne by the public, in the form of higher health care prices and higher insurance premiums.

Of course, rejecting claims is a clumsy way to deny coverage. The best way for an insurer to avoid paying medical bills is to avoid selling insurance to people who really need it. An insurance company can accomplish this in two ways, through marketing that targets the healthy, and through underwriting: rejecting the sick or charging them higher premiums.

Like denial management, however, marketing and underwriting cost a lot of money. McKinsey & Company, the consulting firm, recently released an important report dissecting the reasons America spends so much more on health care than other wealthy nations. One major factor is that we spend $98 billion a year in excess administrative costs, with more than half of the total accounted for by marketing and underwriting — costs that don't exist in single-payer systems.

And this is just part of the story. McKinsey's estimate of excess administrative costs counts only the costs of insurers. It doesn't, as the report concedes, include other "important consequences of the multipayor system," like the extra costs imposed on providers. The sums doctors pay to denial management specialists are just one example.

Incidentally, while insurers are very good at saying no to doctors, hospitals and patients, they're not very good at saying no to more powerful players. Drug companies, in particular, charge much higher prices in the United States than they do in countries like Canada, where the government health care system does the bargaining. McKinsey estimates that the United States pays $66 billion a year in excess drug costs, and overpays for medical devices like knee and hip implants, too.

To put these numbers in perspective: McKinsey estimates the cost of providing full medical care to all of America's uninsured at $77 billion a year. Either eliminating the excess administrative costs of private health insurers, or paying what the rest of the world pays for drugs and medical devices, would by itself more or less pay the cost of covering all the uninsured. And that doesn't count the many other costs imposed by the fragmentation of our health care system.

Which brings us back to the racketeering lawsuit. If UnitedHealth can be shown to have broken the law — and let's just say that this company, which is America's second-largest health insurer, has a reputation for playing even rougher than its competitors — by all means, let's see justice done. But the larger problem isn't the behavior of any individual company. It's the ugly incentives provided by a system in which giving care is punished, while denying it is rewarded.