OPINION

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"Ask yourself one question. 'Is it right?' Then do what you believe is best for your town, your state and country."
– James M. Cox, founder, Cox Enterprises

Punish the greed, not patients in need

Lawmakers should focus on unchecked corporate mismanagement of health care dollars.

By Mark Craig


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As lawmakers consider cuts to Medicaid and Medicare amid rising budget pressures, they must resist the urge to balance the books on the backs of vulnerable patients. The true cost drivers aren't those receiving care, but the corporations profiting from administering it.

In Georgia, Medicaid – the joint federal-state program to care for low-income and disabled residents – is increasingly outsourced to private insurers through managed care organizations. Many of the same corporations that act as MCOs also offer Medicare Advantage plans – private sector alternatives to traditional Medicare care for seniors.

These companies are supposed to deliver efficiency and better outcomes with our taxpayer dollars. Instead, many have built fraud-ridden profit machines – delaying care, denying claims, and overriding doctors' decisions while siphoning billions from public programs.


Mark Craig, chief executive of The Write-Off Warrior health care research and advocacy firm, says the balance of power in health care has dangerously shifted from doctors and hospitals to Fortune 500 companies controlled by Wall Street. RACHEL BUJALSKI/THE NEW YORK TIMES 2024

Insurance company misconduct and misused public funds

Take, for example, Centene Corporation, one of the largest Medicaid managed care operators.

It has paid over $1 billion to settle allegations it overbilled state Medicaid programs through its pharmacy benefit manager. These settlements span at least 20 states.

Georgia has not settled with Centene, despite launching an investigation in 2019. Experts say a Georgia payout could reach $88 million – funds that could support low-income patients.

Centene has admitted no wrongdoing but continues to profit heavily from taxpayer-funded programs, reporting $163 billion in revenue in 2024.

Other MCOs and Medicare Advantage plans face accusations of excessive red tape, slow payments and restrictive authorizations – all designed to maximize profits at the expense of patient care.

UnitedHealthcare – the largest Medicare Advantage provider in the country – is now under criminal investigation for possible Medicare fraud. This isn't an isolated incident; it reflects a systemic pattern.

According to federal watchdogs, Medicare Advantage now costs taxpayers 22% more per enrollee than traditional Medicare, despite delivering no clear improvement in outcomes.

Our recent Write-Off Warrior study found that Medicare Advantage plans are among the most problematic payers for rural hospitals in Georgia and across the nation. Private corporations selling these tax-payer-backed plans require burdensome prior authorizations, routinely deny treatment and practice schemes that starve providers of payment.

Eliminating the most abusive overpayments in the Medicare Advantage program could free up $88 to $140 billion – more than enough to offset the very cuts Washington is proposing.

In other words, we don't need to gut coverage to balance the budget. We need to stop rewarding corporate insurance fraud and manipulation.

The human cost of corporatized medicine

These policies aren't just misusing taxpayer dollars – they're inflicting real harm: delaying treatments, denying essential services and financially destabilizing hospitals.

Nowhere is this crisis more visible than in rural Georgia.

Robin Rau, CEO of Miller County Hospital in Colquitt, notes in an interview that most patients at rural hospitals like hers are not privately insured. Cutting Medicaid funding, as outlined in a bill that just passed the U.S. House of Representatives, would do real harm to rural hospitals, she says.

"Medicaid today represents 50% of all our cash collections," she says. "The proposed reduction will dramatically dim our future and will place this rural hospital and many others in jeopardy."

Rau also points to a deeper, systemic issue: Insurers have "taken all the control away from doctors and hospitals," she says, adding, "They're now the drivers of healthcare, not the clinicians."

Doctors speaking up on behalf of patients

Physicians, too, are sounding the alarm.

"The most disheartening aspect of being a clinician is realizing that the care my patients receive often hinges not on my years of training and expertise, but on algorithms designed to profit insurance companies," Dr. Toby Terwilliger, a physician in Atlanta who chairs the Georgia Chapter of Physicians for a National Health Program, said in an interview.

"When I get on the phone with an insurance agent, pleading with them to pay for essential medical services, only to have a nonmedically trained representative on the other end tell me my patient doesn't qualify for arbitrary reasons, I feel utterly powerless."

Medicaid and Medicare were never designed to thwart doctors, harm patients or enrich corporate insurers. They were built to ensure access to care for those who need it most.

But the balance of power has dangerously shifted – from doctors and hospitals to Fortune 500 companies controlled by Wall Street. As their profits soar, so do hospital closures and patient bankruptcies, and the physician shortage gets exacerbated.

The way forward: Rein in profiteering insurance corporations

This system of corporatized medicine is not sustainable.

Rather than slashing benefits or limiting coverage, lawmakers should focus on the true source of waste: unchecked corporate mismanagement of public healthcare dollars.

It's time to hold these insurers accountable by strengthening oversight, restoring clinical authority to healthcare professionals, and ensuring that taxpayer dollars go where they belong – into frontline care, not shareholder dividends.

If lawmakers are serious about reducing costs in Medicaid, the solution isn't punishing patients and hospitals. It's cutting fraud and abuse by profiteering insurance corporations.

Mark Craig is the chief executive of The Write-Off Warrior, a Georgia-based research and advocacy firm focused on improving health care access.