Caught in The Middle: Unraveling Payer-Provider Blame in United States Healthcare

by John Crable, Senior Vice President

In 2025, the national conversation around healthcare sharpened, shifting beyond coverage debates to focus on why care remains so expensive, confusing and inefficient for many. Amid rising public frustration, insurance companies were cast as the primary villains, accused of inflating costs, denying necessary care and creating roadblocks for patients and providers.

While these problems themselves are valid, the truth behind our system's dysfunction is more complex than any one narrative allows. The real issue isn't one payer, one policy or one bad actor. It's a deeply fragmented system built on competing incentives, misaligned responsibilities and layers of administrative friction.

To fix what's broken, we need to understand how each stakeholder operates, where inefficiencies creep in and how the system can be realigned to deliver better outcomes for all.

When Denial is a Business Model

There has long been tension around how insurers manage claims. Some resolve them upfront with a "pay now, audit later" approach for faster processing but more downstream administrative cleanup. Others use aggressive, upfront filtration, which involves strict cost control that drives high initial denial rates.

Providers are under pressure to do more. According to MIT economics professor Jonathan Gruber, defensive medicine—ordering extra tests to avoid liability, confirm diagnoses or satisfy patients—is widespread. In a fee-for-service model, providers and facilities are financially rewarded for volume rather than value.

Patients, too, often expect unlimited access to care. The system encourages overuse. Patients often want every test or treatment available, even without clarity on cost or clinical necessity. Without reliable quality metrics, many rely on referrals, brand recognition or advertising to guide decisions, further swelling demand without regard for efficiency.

That combination of overuse and opacity leaves insurers as the sole gatekeepers of cost. We have tasked carriers with managing out-of-control healthcare spending, even as we blame them for delaying or denying care. The result is a high-stakes tug-of-war: Valid claims can get tied up in appeals, delaying care or reimbursement and piling on administrative burden. For example, routine prescriptions like birth control pills are sometimes denied due to simple coding mistakes.

Both denial models reveal how misaligned incentives and information gaps have baked inefficiency into the system, with pressure to overuse on one side and underwrite on the other. Only by understanding that dynamic can we begin to realign incentives and ease the burden on patients and providers alike.

The Invisible Drain: Fraud, Waste and Coding Games

Unneeded care drives roughly $210 billion in waste yearly, accounting for about one-quarter of total U.S. health spending. A national Johns Hopkins survey of more than 2,000 physicians found that most believe 15 to 30% of the care they deliver is unnecessary, with clinicians estimating that about 22% of prescriptions, 25% of tests and 11% of procedures fall into that category.

For instance, a landmark study demonstrated that 73% of patients with uncomplicated acute appendicitis treated initially with antibiotics did not require surgery within one year, challenging our reflexive default to appendectomy and highlighting how clinical norms, not patient need, often drive intervention.

Cost and quality rarely align. A single heart bypass procedure varies from $40,000 at one hospital to $448,000 at another, with no measurable difference in patient outcomes. Such extreme price dispersion underscores how little price signals reflect true value.

Excessive and unnecessary services also drive up patient bills. Roughly 1.3% of Americans with medical bills in collections have experienced wage garnishment, a practice most common among nonprofit hospitals receiving public funding.

Meanwhile, insurers' negotiation leverage keeps sticker prices from spiraling even higher. Commercial payers routinely secure rates averaging 58% of hospital chargemaster prices, sparing patients from substantially steeper bills that would come with full chargemaster charges.

Layer on inconsistent standards for billing, coding and reimbursement, where a single miscoded entry can trigger a denial or surprise bill, and it becomes clear: Inefficiency isn't a side effect; it's baked into the system's design.

A System Out of Sync and a Path Forward

Insurers sit at the center of America's healthcare dysfunction, responsible for balancing access, cost and utilization in a system where everyone else is incentivized to say yes. Patients want reliable access to care. Providers want to deliver and be reimbursed for every service. Pharmacies want to fill every prescription.

Even employers question this gatekeeper role. Corporate leaders chafe at requirements for prior authorizations, viewing them as needless interference in clinical decision-making, yet they also face rapidly escalating premiums and deductibles that threaten their workforces. Abolishing utilization management would only shift those rising costs directly onto employees and businesses, making today's unaffordable landscape look tame by comparison.

But even as utilization management draws ire, overall healthcare costs continue to climb. Common surgical procedures, once relatively affordable, now vary dramatically in price depending on coding, location and payer negotiations. If we do not get a handle on inflated costs for basic services, meaningful reform will remain out of reach.

The path forward begins with realignment: convene payer and provider teams around shared outcome metrics, pilot value-based contracts and scale programs that steer patients toward high-performing providers or centers of excellence.

The frustration patients feel is real and justified. To create lasting change, their frustration must be transformed into action. That means expanding the conversation, looking honestly at how each part of the system contributes to dysfunction and building consensus around smarter, more sustainable models. Patients still struggle to navigate care and costs without clear pricing or quality information, underscoring that real reform also depends on empowering them to make informed choices.

The people closest to the friction—those managing claims, correcting codes and helping patients navigate denials—know where the system breaks down. The next phase of reform will come from listening to those who understand the system best and involving them directly in how we redesign it. For policymakers, plan sponsors and health system leaders, the charge is clear: champion front-line insight, forge true shared accountability and deliver a healthcare system that rewards results—not volume.

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