2024 IN REVIEW

THE GILDED AGE OF MEDICINE *IS* HERE

Health insurers and hospitals increasingly treat patients less as humans in need of care than consumers who generate profit.

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Illustration by Sean Dong

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In 2010, a private-equity firm called Cerberus Capital Management, which is named for the three-headed dog that is said to guard the underworld, bought

six Catholic hospitals in Massachusetts and christened the chain Steward Health Care. The state's attorney general blessed the deal on multiple conditions, including that, during a five-year review period, the hospitals stayed open and their workers stayed employed. A few months after the period ended, however, Steward started selling the land on which the hospitals stood. A $1.25-billion-dollar deal, in 2016, helped to finance more acquisitions. Many facilities, asked to pay rent on land they'd previously owned, struggled.

According to a recent report published by Massachusetts Senator Ed Markey's office, which covers the period between 2017 and 2024, some Steward facilities had to forgo key investments in staffing, surgical equipment, elevator repairs, and even clean linens. Patients increasingly languished in emergency rooms; many left without receiving care; and mortality rates for common conditions climbed sharply. (Steward has argued that its death rates were better than expected, given the underlying health status of the patients it cared for.) A hospital in Florida developed a bat infestation, and another, in Texas, was cited for placing potentially suicidal patients in rooms with materials with which they could hang themselves. Employees at Steward's Carney Hospital, in Massachusetts, began calling their workplace "Carnage" hospital. (Cerberus's ownership ended in 2020, and the firm claims that the quality issues at Steward are "overwhelmingly related to the post-Cerberus ownership period.")

In May, Steward filed for bankruptcy. It has closed two hospitals and plans to sell thirty-one others. Steward's C.E.O., Ralph de la Torre, who in 2011 purchased a

forty-million-dollar superyacht, was subpoenaed by a Senate committee but failed to show up; he was held in contempt of Congress and resigned from his position. (De la Torre, in turn, sued the committee for violating his right against self-incrimination.) Nonetheless, Cerberus realized a profit of seven hundred and ninety million dollars from its investment in Steward. Meanwhile, in some places in the U.S., private-equity firms now own more than half of all medical practices within certain specialties. "We are being picked clean by private equity," a New Jersey-based radiologist said at a recent meeting of the American Medical Association. "There are people who don't know where their next paycheck is even going to come from because their groups have been flipped so often."

2024 was arguably the year that the mortal dangers of corporate medicine finally became undeniable and inescapable. A study published in *JAMA* found that, after hospitals were acquired by private-equity firms, Medicare patients were more likely to suffer falls and contract bloodstream infections; another study found that if private equity acquired a nursing home its residents became eleven per cent more likely to die. Although private-equity firms often argue that they infuse hospitals with capital, a recent analysis found that hospital assets tend to decrease after acquisition. Yet P.E. now oversees nearly a third of staffing in U.S. emergency departments and owns more than four hundred and fifty hospitals. In some of them, patients were "forced to sleep in hallways, and doctors who spoke out were threatened with termination," according to Jonathan Jones, a former president of the American Academy of Emergency Medicine.

Erin Fuse Brown, a professor at the Brown University School of Public Health, told me that private-equity firms have learned that they "don't have to make things better or make them more efficient. You can just change one small thing and make a ton more money." They are hardly the only corporations to learn this lesson. Increasingly, health insurers, private hospitals, and even nonprofits are behaving as though they aim first to extract revenue, and only second to care for people.

Patients often are viewed less as humans in need of care than consumers who generate profit.

In 1873, Mark Twain co-wrote the novel "The Gilded Age: A Tale of Today," which satirized an era that was marked by inequality, greed, and moral decay but was painted in a veneer of abundance and progress. Industrialists made fortunes in oil, steel, and shipping even as millions suffered poverty and exploitation. Today, health care is where the money is. New technologies and treatments sustain the impression that patients have never been healthier, but corporations and conglomerates wield immense power at the expense of the people they're meant to serve. Welcome to the Gilded Age of medicine.

In recent years, health-care corporations have embraced an approach that can only be described as gamification. In the U.S., all seniors over sixty-five are entitled to health insurance through Medicare, and, for several decades, private companies have offered plans through programs such as Medicare Advantage. The government pays insurance companies a fixed sum based partly on how sick those patients are. The sicker the patients, the bigger the potential payments. But who's to say, really, how sick a patient is? Let the games begin.

This year, the health-news site *STAT* revealed that UnitedHealth, the country's largest private insurer, had set up dashboards for practices to compete on how many conditions they could diagnose in patients. Doctors who completed the most appointments with seniors in Medicare Advantage were eligible for ten-thousand-dollar bonuses, and patients were offered seventy-five-dollar gift cards for getting checkups at which their medical histories could be recorded. At the height of the COVID-19 pandemic, an e-mail sent to one practice told clinicians that documenting chronic illnesses was the "#1 PRIORITY."

Insurance companies have even started to scour medical records for possible diagnoses, and to send nurses to patients' homes to perform "health-risk

assessments." These strategies rack up so many additional diagnoses that, in 2023 alone, the federal government made $7.5 billion in "overpayments" to insurers, according to the U.S. Office of the Inspector General. Insurers are "pouring tremendous resources into developing the capacity to code patients in a way that nets more money from Medicare," Donald Berwick, a former head of the Center for Medicare & Medicaid Services, told me. "That's taxpayer money being siphoned away from people who need it."

Berwick said that his own physician's practice had recently been acquired by UnitedHealth. One day, he asked his doctor, "Anything different now?"

"Two things," the doctor replied. "I have to see more patients each day. And my patients have new diagnoses that I didn't put there." Many patients with atrial fibrillation, for example, were now coded as having another condition known as "hypercoagulable state"—which was technically accurate, but didn't change patients' care in any way. It did, however, generate higher payments from Medicare. Ask not what your insurer can do for you—ask how much revenue you can generate for your insurer.

The insurance companies in Medicare Advantage tend to argue that they're simply recording diagnoses, not making them up; that they offer vision and dental benefits that traditional Medicare doesn't offer; and that they rein in unnecessary care, such as by requiring prior authorization for certain tests and procedures. But according to the Medicare Payment Advisory Commission, a nonpartisan agency that counsels Congress, private Medicare Advantage plans will cost the federal government eighty billion dollars more per year than if those patients had been in the traditional Medicare program. "You might as well flush most of that eighty billion dollars down the toilet," Berwick told me.

On December 4th, after I drafted this piece, Brian Thompson, the C.E.O. of UnitedHealthcare, was fatally shot in midtown Manhattan. In the days that followed, the public response was not just one of shock but also of frustration and

even rage against the health-insurance industry. Someone posted in a subreddit for nurses, "Honestly, I'm not wishing anyone harm, but when you've spent so much time and made so much money by increasing the suffering of the humanity around you, it's hard for me to summon empathy that you died." The comedian Bill Burr compared C.E.O.s like Thompson to gangsters. "It's a dirty game," he said. "Health care—dirty game." I was saddened by the callousness of these comments. Thompson had become a symbol of a broken system; people who devalued his life, it seemed to me, were engaging in a version of the dehumanizing behavior that they found objectionable within the health-care industry.

A few years ago, I cared for a woman I'll call Sally. About a week before I met her, Sally began to feel a soreness in her belly. As her symptoms progressed —she became fatigued and developed a burning sensation when she peed—she considered going to an urgent-care clinic or an emergency room, but, concerned about the expense, she decided to stay home. Sally's employer, a nearby nonprofit hospital, had recently tightened its insurance offerings, and she was now in a high-deductible plan, meaning that she would be expected to cover much of the initial cost of the care that she received. Many health workers are no longer able to afford care from the very institutions that they work for. By the time I saw Sally, she was feverish and shaking with chills. A urinary-tract infection that might have been quelled with a few pills had spread to her bloodstream. Her heart raced; her blood pressure fell. It took more than a week for her to recover.

It would be nice if nonprofit health care were the antidote to corporate health care. Instead, each year, it seems to look more like for-profit medicine. The *Times* recently reported that Providence, one of the nation's largest not-for-profit health-care organizations, sicced debt collectors on poor patients who were entitled to free care. Providence, which was founded in the eighteen-fifties by nuns committed to "serving all, especially those who are poor and vulnerable," recorded annual revenues in excess of twenty-seven billion dollars in 2021. Like other

nonprofits, it benefitted from enormous tax breaks, yet only one per cent of its expenses went to charity care. Allina Health, a nonprofit based in Minnesota, denied care to patients, including children, with unpaid bills, placing them in a kind of medical debtors' purgatory. Both systems said that they would discontinue these practices after these stories broke, but other hospitals still have policies of suing patients, obtaining court orders to garnish their wages if they fail to pay, and even placing liens on their homes.

Meanwhile, an increasingly consolidated health-care industry has engendered the kinds of too-big-to-fail behemoths that can single-handedly paralyze the system. Health care accounts for more than seventeen per cent of the U.S. economy, or around four and a half trillion dollars, but the revenues of just two companies—CVS/Aetna and UnitedHealth—account for nearly one in every seven dollars the nation spends on health care. In February, a ransomware group called Black Cat executed a cyberattack on Change Healthcare, a clearinghouse for medical claims that enables payments to doctors, hospitals, and pharmacies. The company was acquired by UnitedHealth in 2022, over antitrust objections from the Department of Justice, and became embedded in nearly every part of the health system. The cyberattack compromised the medical records of around a hundred million patients, and profoundly disrupted the flow of data and payment. Patients couldn't get their medications covered; doctors struggled to get treatments authorized; medical clinics, unable to meet payroll, were pushed to the brink of insolvency. In the end, UnitedHealth paid a bitcoin ransom worth some twenty-two million dollars, and the system lurched back online.

"Data is the oil of the health-care system," Brown, the public-health professor, told me. She recalled another major ransomware attack that targeted the Colonial Pipeline, which carries gasoline from Texas to the southern and eastern United States. "Data is the raw material, the critical infrastructure, that facilitates the flow of money. If you control the data, you get to say how sick patients are. You get to say how well you're caring for them. You get to control the money."

When I was in medical school, a mentor of mine, Mark Mercurio, told me a story from his own medical training. One evening, after midnight, a neurologist paged him and asked him to help check on an older patient who'd been unconscious for a few days. Reluctantly, Mercurio made his way from his call room, where he'd settled in for a nap, to the patient's room. There, he found the neurologist gently tapping a reflex hammer on the patient's forearms and knees, carefully recording any change from the previous night.

Mercurio suggested that the neurologist speed up—it didn't seem much could be gained by examining a man whose condition hadn't changed from the night before—but the neurologist proceeded, exposing as little of the patient's body as possible, determined to preserve the patient's dignity. After he finished, he tucked a blanket neatly under the man's neck. Mercurio remembered the moment as simple but astonishing. The patient had suffered a devastating brain injury; he was unlikely to recover consciousness. Yet in the middle of the night, without any thought of insurance payments or performance reviews, a physician had given the kind of care and attention that we all hope our loved ones will receive.

One of the things I love most about medicine is its peculiar professional ethic: a norm, taken as given, that physicians will provide counsel and care independent of self-interest, and treat patients equally, regardless of their biography, condition, or ability to pay. It is because doctors are understood to place patients' interests above commercial ones that they have long enjoyed professional autonomy and public trust. The history of medicine is too littered with incompetence and immorality to believe that doctors have always been worthy of this status. Still, something profound is lost when we submit to the jaundiced view that medicine is a business like any other. There is value in striving for something higher.

Today, medicine is awash in the language of economics. Patients are consumers; doctors are providers; health care is a commodity. "Now that all bets are off, and everything is getting corporatized, we're realizing how much work the professional ethos was doing to protect patients," Brown told me. It's not that any talk of

money should be rejected—hospitals and clinics need to keep the lights on, after all. But we need counternarratives to revive medicine's social contract and to help curb the kind of financial gamesmanship that has become accepted and pervasive. "I don't drag my ass out of bed at two in the morning for consumers with no money," Mercurio told me. "For a patient with no money, I do it all the time."

There have been hints of an ebb in the tide of corporatization. Lawmakers appear increasingly concerned about unwarranted payments to Medicare Advantage insurers, and are trying to curb excessive patient diagnoses. Senator Ed Markey, of Massachusetts, the epicenter of the Steward Health Care debacle, along with Representative Pramila Jayapal, of Washington State, has proposed legislation that would require more scrutiny of private equity in health care and would penalize firms that engage in understaffing or price gouging. Some states are trying to revive dormant "corporate practice of medicine" laws intended to limit unlicensed, for-profit entities from owning health-care organizations or delivering medical care. Meanwhile, federal antitrust agencies have suggested that they plan to take a more aggressive approach toward anticompetitive behavior, and doctors around the country are unionizing at unprecedented rates. In June, the American Medical Association adopted a resolution on physician unionization, citing corporate dominance in health care and a growing "moral injury related to an incongruence between what physicians care about and what they are incentivized to do by the health care system."

A few weeks ago, I reached out to Walter J. O'Donnell, a pulmonary and critical-care physician at Massachusetts General Hospital, where I completed my medical training. O'Donnell—or W. O. D., as trainees liked to call him—was the type of doctor I aspired to be. He was kind, attentive, devoted, and generous with his time and expertise. In residency, there were intimidating senior physicians whom I'd hesitate to page if a patient was having a heart attack; I felt that I could text O'Donnell at midnight about someone's ingrown toenail.

O'Donnell told me about a middle-aged man he cared for a couple of years ago. The patient, a longtime smoker, had been admitted to the hospital with worsening emphysema and debilitating leg pain, owing to a narrowing of the arteries in his thighs. When O'Donnell discharged him, the man was to be automatically enrolled in a hospital-run smoking-cessation program, and also agreed to undergo a surgery to open up the vessels in his legs. A few weeks later, O'Donnell received an urgent page: the man had started smoking again and was desperately short of breath. He had tried to get help with quitting, O'Donnell told me, but the hospital's smoking-cessation program had quietly been discontinued. The man's emphysema progressed, which prevented him from getting the surgery. This past year, he died.

O'Donnell's story reminded me of the insidious way in which an organization's culture and purpose can shift. Although the hospital's smoking-cessation program was highly successful, with quit rates approaching seventy per cent, there is never a guarantee that it will save the life of a particular patient, or generate much revenue. That is precisely why administrators could cut it. Over time, the deprioritization of less-profitable services—addiction-medicine consults, for instance, or labor-and-delivery care—in favor of more lucrative ones can render the mission of medical care unrecognizable.

Lately, O'Donnell has become more outspoken about the "utter dominance of business values in health care." He recently convened a conference on what he calls "administrative harm"—the damage inflicted by administrators who increasingly make the most consequential decisions, often unilaterally, about who and what gets prioritized in a medical system. "Even a few years ago, you'd stop by the cafeteria and bump into an administrator," O'Donnell said. "You could feel that they were accountable to you. They had this sense that, 'Well, I could cut this program, but I know I'm going to see the head of surgery in the hallway, so I'd better have a good answer for him.' " But a recent study of fifteen leading academic medical centers found that nearly half of their board members worked in

finance, and only fifteen per cent were medical professionals. According to KFF Health News, not a single nun serves in a top role at the nation's more than six hundred Catholic hospitals. Sister Generose Gervais, a longtime administrator of the Mayo Clinic, is often quoted as saying, "No money, no mission." A hospital can't care for patients if it can't pay for itself. But, O'Donnell told me, "people forget the second half of what she said: no mission, no need for money." ♦

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