

When an Insurance Rep Calls Mid-Surgery: *What's the Real Breakdown?*

Jared Rhoads

An incident involving Dr. Elisabeth Potter, a breast cancer surgeon in Texas, has gone viral—and for understandable reasons. According to multiple reports, Dr. Potter paused mid-surgery to take a phone call from UnitedHealthcare about approval for her patient's procedure. Dr. Potter posted a video of the phone call online, letting everyone see the process from her point of view. It's a jarring scene: a physician, just scrubbed out, stepping away from the operating table to argue a case with an insurance representative. Post-Mangione, it's another test case for American health insurance.

It's easy to sympathize with Dr. Potter and to see UnitedHealthcare's behavior as invasive, corporate overreach. And it very well might have been. But there's a deeper question worth asking: Why is it that insurers are even in this position to begin with?

In the United States, we've built a healthcare system that places nearly the entire burden of cost containment on insurance companies. Our thought leaders in politics and policy have implicitly and explicitly supported the idea that an increasing number of services ought to be covered by insurance, that patients should not have to ask about the cost of the care they receive, and that doctors should not have to consider cost when recommending tests or treatments.

That approach leaves insurers as essentially the only entity responsible for exercising any cost-consciousness. They can acquiesce to everything, and raise premiums the next year. Or they can get involved in the game of denials and prior authorizations, which makes them appear the villain.

A popular reaction is to call on insurance to "stay in their lane" and "just pay the bills." This might sound nice, but if no one at all has any responsibility or incentive to be cost-conscious, healthcare spending will continue to rise, causing premiums to do the same.

To be sure, insurance companies bear some responsibility for the broken status quo. They have hardly been consistent proponents of free-market ideas. They supported the Affordable Care Act's individual mandate because they weren't willing to push back against expanded coverage mandates. They've lobbied to make it harder for alternative models such as direct primary care and health sharing organizations to get started. They've supported regulations that increase

compliance costs, knowing that doing so creates barriers that new market entrants cannot overcome but they can. In more ways than one, they've helped to create the problem they now are entangled with.

Some will look at this story and conclude that the answer is more regulation. Others will argue this is precisely why we need a government-run system. “Get rid of the middlemen and let doctors practice medicine without interference,” is a popular view. But the American frustration with private insurance does not prove the need for a Canadian- or European-style system. Those systems struggle with cost-containment, too, but the extent to which they “do better” comes primarily from placing the cost-control role with the government instead of an insurance company. Decisions made by government bodies are even less flexible than ones made by private insurance. Those systems make coverage decisions more categorically, publishing lists of surgeries and procedures that they consider of “limited clinical value” and denied to everyone in all but the most exceptional cases.¹

If we want to change course, we should check our premises. Contrary to the orthodox view, patients and doctors can and ought to work together to make cost-informed health decisions.

One way to get insurance companies out of the operating room would be for insurers to provide a predetermined, reference-based lump sum for a given medical condition or procedure. For example, if a patient needs a knee replacement, the insurer would pay a flat amount—say, \$18,000—based on a benchmark price derived from market averages. The patient and doctor then choose how and where to get that procedure done, with access to transparent pricing across providers. Currently, this approach isn’t specifically prohibited by law, but network adequacy laws and medical loss ratio laws can make this model treacherous for insurers to implement.

The above model accomplishes several things at once. First, it restores cost-consciousness to the doctor-patient relationship. If a provider quotes a figure that is more than the lump sum, the patient may decide to pay the difference out of pocket, or go elsewhere. If the provider charges less, the patient could keep the savings or use them for related follow-up care. Either way, the patient and physician are now empowered to weigh which option is best for the patient’s life in full context, instead of merely comparing clinical details in isolation.

Second, this model creates real price competition among providers. When providers know that patients are shopping with a fixed budget in hand, they have an incentive to offer better value—lower prices, higher quality, or both. This is in stark contrast to today’s opaque billing practices and negotiated discounts that hide the real cost of care and discourage innovation.

Third, it redefines the role of the insurer. No longer would insurers scrutinize and deny claims line-by-line. Their job would be to determine reasonable reference prices up-front, not to referee clinical decisions over the phone with surgeons mid-procedure.

Ultimately, the way out of this dysfunction is not more centralized control or top-down regulation. It's decentralized choice, guided by prices. If we find denials and prior authorization reviews so distasteful, then let's make a course correction to a system where patients and doctors once again make the decision, uninterrupted, and accept the cost-related responsibility for their choice.

About the Author

Jared Rhoads is Director of the Center for Modern Health.
Email address: jared.rhoads@centerformodernhealth.org.

Declaration of Conflicting Interests

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