# Putting Profits Over Patients:

## HOW THE CORPORATIZATION OF AMERICAN HEALTHCARE IS IMPACTING DIVERSE COMMUNITIES

HEALTH EQUITY COLLABORATIVE

White Paper

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The Health Equity Collaborative

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HEALTH EQUITY COLLABORATIVE

## About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is officially a project of MANA Action, a 501c4 not-for-profit organization.

# Introduction

Over the past three decades, the American healthcare system has evolved into a complex maze of large corporate conglomerates and bureaucratic processes, placing increased strain on the doctor-patient relationship. Hospital mergers have failed to deliver the promised benefits, and patient-focused care has given way to more impersonal and costly treatments as insurance companies have increasingly influenced doctors' day-to-day decisions. Costs have risen and the quality of care has declined. Diverse communities are at the most significant risk from these negative trends. This paper will review the transformation of American medicine into the corporate 'colossus'1 we know today and how this transformation adversely impacts diverse communities. It identifies several challenges facing underserved populations and policy reform options to restore the doctor-patient relationship and usher in a more caring future for all.

# Today's Corporate Healthcare System


Despite astonishing advances in science and technology that hold the potential to improve healthcare outcomes – dramatically and for all – the U.S. healthcare system itself is sick and unable to perform in the patient-centered, results-oriented fashion that a well-functioning healthcare system should.[2] Instead of marrying available technology with empowered doctors and patients, "our medical advances are funneled through a veritable gauntlet of gatekeepers, distributors, middlemen, subcontractors, loophole-exploiters, conglomerates, and monopolies, all under the watchful eye of Wall Street investors."[3]

> **THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) ESTIMATE THAT HEALTHCARE COSTS HAVE MORE THAN QUINTUPLED SINCE 1990, EVEN AS CONSOLIDATION IN THE HEALTHCARE SYSTEM PROMISED TO REDUCE COSTS.**

The U.S. healthcare system is the most expensive in the world, yet one where doctor shortages, nurse shortages, general healthcare worker shortages, routine drug shortages, and medical supply shortages pervade. Three in ten dollars spent on healthcare go toward administrative overhead. One in ten is the cost of fraud, fifty times more than is spent on fraud prevention.[4]

The Centers for Medicare and Medicaid Services (CMS) estimate that healthcare costs have more than quintupled since 1990, even as consolidation in the healthcare system promised to reduce costs. CMS projects healthcare spending to reach $6.2 trillion in 2028. Experts predict out-of-pocket expenses will rise 10 percent per year through 2026. Yet for all this spending (the OECD estimates the per capita cost of healthcare in the U.S. is almost double that of most industrialized countries), the U.S. does not have "discernably better" health outcomes.[5] Instead, there is a system where doctor-patient relationships do not come first, access to drugs and treatments is too often limited or nonexistent, patient costs are skyrocketing, and programs for underserved communities have veered from their mission.

# Five Areas of Corporate Healthcare Failure

The corporate healthcare model, as currently structured, has failed. It has especially failed vulnerable populations who lack the means to access and pay for ever more expensive services and treatments. The harm to vulnerable populations has been particularly acute in five areas: insurance and hospital consolidation, rising costs, quality of coverage and care, administrative bureaucracy, and price transparency.

# 1. CORPORATE CONSOLIDATION

Amidst rising healthcare costs in the 1990s, many policymakers and corporations successfully promoted hospital and health system mergers as a solution that would reduce inefficiencies and lower prices. Consolidation, not competition, was to be the key to affordable, quality healthcare. Over the next thirty years, the Federal Trade Commission (FTC) approved hundreds of corporate healthcare mergers. Today, it is clear the prediction that reducing competition would reduce prices was false. In retrospect, the rising costs and reductions in quality of care that followed consolidation were the exact opposite of the promise made.[6] One analysis found that hospital and health system mergers have increased prices from 6 to 17 percent.[7]

Hospital and health system mergers also endanger patient access for diverse communities. To save on business costs, merged hospitals and health systems may eliminate certain healthcare services in their new communities. A distant corporate health system may also reduce or eliminate local community spending, disproportionately impacting communities in need of financial assistance.[8] At a January 2023 University of Pennsylvania Leonard Davis Institute of Health Care Economics seminar, Lois Uttley, MPP, observed:

> *The unfortunate reality is that more than 25 years of market-driven health facility consolidation has really left too many communities across the U.S. without timely access to needed care. Residents of urban neighborhoods of color and rural areas have suffered a lot as independent hospitals have closed or joined big health systems. Acquiring systems often move to close services like intensive care, labor and delivery, psychiatric care, and cardiac surgery. It forces people to travel out of their communities and poses really serious navigation issues for patients, especially those who are disabled, elderly, non-English speaking, and without their own cars.*[9]

Further, consolidation has severely strained the medical professionals many rely on the most—their doctors. Reports abound of doctors forced to choose between the demands of administrators, hospital executives, and insurance companies (i.e., corporate profits on the one hand, and their professional ethics on the other).[10] Doctors

are frequently not the professionals making the critical decisions regarding a patient's care. Yet many doctors remain silent about their concerns, fearing retribution for speaking out.[11]

The removal of authority from doctors has taken a psychological toll and harmed morale in the profession.[12] Like many flaws in the healthcare system, the risk of a consequent doctor shortage would most acutely threaten underserved communities.

In a further removal of power from patients and doctors, private equity has invested heavily in the healthcare system. Critical decision-making power can be taken outside the healthcare system when this occurs. One estimate even has private equity firms overseeing 30 percent of all emergency room staffing in the U.S. Diverse communities are particularly affected by this development since they tend to be more reliant on emergency room care.[13]

Another area of healthcare system consolidation is among pharmacy benefit managers (PBMs). PBMs negotiate prices with drug manufacturers and pharmacies, with the intended purpose of reducing drug prices for patients. These savings, however, are often not passed along to patients.

Like much of the healthcare system, the PBM industry has consolidated rapidly, with three firms controlling almost 80 percent of the market. Insurance companies frequently have large stakes in PBM ownership. PBMs often own pharmacies, too. This corporate consolidation and reduction of competition has resulted in higher drug prices for patients.[14]

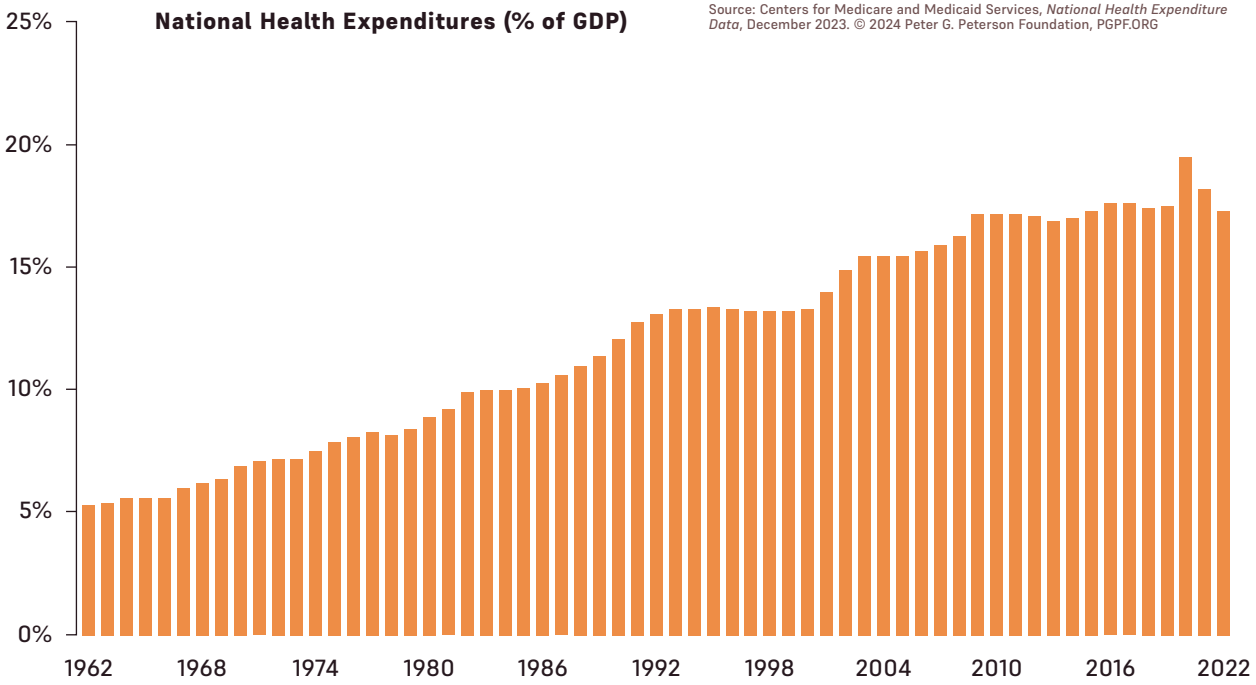
**DOCTORS ARE FREQUENTLY NOT THE PROFESSIONALS MAKING THE CRITICAL DECISIONS REGARDING A PATIENT'S CARE. YET MANY DOCTORS REMAIN SILENT ABOUT THEIR CONCERNS, FEARING RETRIBUTION FOR SPEAKING OUT.**[11]

# 2. RISING COSTS

In July 2023, the Peter G. Peterson Foundation reported:

> *The United States has one of the highest costs of healthcare in the world. In 2021, U.S. healthcare spending reached $4.3 trillion, which averages to about $12,900 per person. By comparison, the average cost of healthcare per person in other wealthy countries is only about half as much. While the COVID-19 pandemic exacerbated the trend in rising healthcare costs, such spending has been increasing long before COVID-19 began. Relative to the size of the economy, healthcare costs have increased over the past few decades, from 5 percent of GDP in 1960 to 18 percent in 2021.*[15]

## HEALTHCARE COSTS IN THE UNITED STATES HAVE INCREASED DRASTICALLY OVER THE PAST SEVERAL DECADES[15]

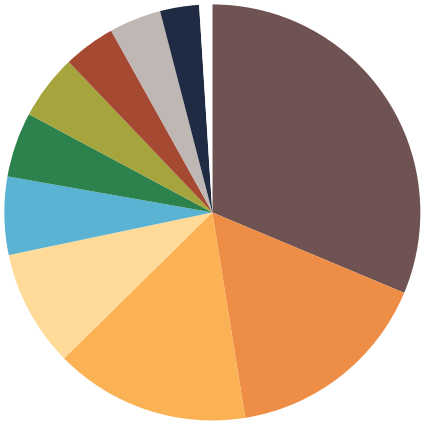


In a 2022 Kaiser Health Foundation survey, half of U.S. adults said they struggled to afford healthcare. 60 percent of Black Americans reported having this difficulty, as did 65 percent of Hispanics. Affordability concerns lead many people to delay or skip healthcare services. Respondents most frequently skipped dental and vision services, but 24 percent of respondents had skipped a doctor's visit in the past year, 18 percent had skipped a mental health care, and 14 percent had skipped a hospital service.[16]

An aging U.S. population is partly responsible for increases in healthcare spending, as people aged 65 and older spend more on healthcare than any other age group.[17] This factor, however, is one of many driving healthcare cost increases. The prices of healthcare services have been rising faster than the inflation rate for most of the last quarter century.[18]

According to a recent study of trends in healthcare spending published by the American Medical Association (AMA), the primary drivers of rising healthcare costs include hospitals, physician services, and personal health expenditures.[19]

## THE U.S. SPENT $4.26 TRILLION ON HEALTH CARE IN 2021. WHERE DID IT GO?[20]



Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical. Table 2, 9, and 10 in NHE Tables [ZIP].

| | | |
|---|---|---|
| Hospital Care | 31.1% | **$1.32 Trillion** |
| Other Personal Health Care | 16.0% | **$680 Billion** |
| Physician Services | 14.9% | **$633 Billion** |
| Prescription Drugs | 8.9% | **$378 Billion** |
| Net Cost of Health Insurance | 6.0% | **$256 Billion** |
| Clinical Services | 5.4% | **$231 Billion** |
| Investment | 4.9% | **$207 Billion** |
| Government Public Health Activities | 4.4% | **$188 Billion** |
| Nursing Care Facilities | 4.3% | **$181 Billion** |
| Home Health Care | 2.9% | **$125 Billion** |
| Government Administration | 1.2% | **$52 Billion** |

When it comes to lowering costs, prescription drug prices have become a focal point for lawmakers and political leaders. However, the data makes clear that drug prices are not the primary driver of increased costs.

Hospital care — the largest source of spending — totaled $1.32 trillion, or 31.1 percent of overall healthcare spending. Physician services cost $633.4 billion, or 14.9 percent of the total. And "other personal health care" costs represented $680.4 billion, or 16 percent of total spending. Prescription drugs accounted for just $378 billion, or less than nine percent, of the total $4.26 trillion spend on healthcare.[20]

Healthcare cost increases are also due to webs of rules and regulations that vary from system to system. The price of medical malpractice insurance has driven prices upward, too. Americans also increasingly suffer from chronic illnesses that, when not effectively managed, drive up healthcare costs. This suffering and cost is borne particularly by people of color.[21]

Two other – inadvertent – drivers of cost increases are employer-provided and government-provided health insurance. While well-intended, these systems prevent consumers from making informed decisions based on knowledge of a service's actual cost. Moreover, when these insurance programs have payment limits, their costs are often transferred to other healthcare consumers.[22]

In 2024, employers face the largest healthcare costs increases in more than a decade. Employer healthcare rose by 5.4% – 8.5% and these costs are likely to passed on to employees.[23]

Increases in health insurance costs for employers are felt most severely by low-income workers. The Center for American Progress noted in late 2022:

> *[T]he burden tends to be greater for lower-income workers: Firms with a greater number of low-wage employees on average contribute 10 percent less toward single coverage premiums and 13 percent less to family coverage premiums than those with fewer low-wage employees. As premiums rise, the cost of health insurance grows as a share of total compensation, cutting into employees' take-home pay.*[24]

# 3. LOWER QUALITY COVERAGE

A Kaiser Family Foundation (KFF) survey found that patients in poor health are twice as likely as those in good health to give their health insurance a negative rating. Common insurance issues include denial of coverage, lack of access to providers, difficulty obtaining pre-authorization for services, inadequate prescription drug coverage, and lack of mental health coverage.[25]

The KFF survey also found that many people did not know how to appeal an initial insurance company decision and could not resolve their issues satisfactorily. Many respondents reported out-of-pocket costs that were higher than expected. Delaying or foregoing services – which can lead to poorer health and higher long-term costs – was a common reaction to insurance problems.[26]

Another challenge, specifically facing communities of color, is limited access to language services for patients that have limited English proficiency. Despite research showing interpreters improve health outcomes, not all insurers will reimburse patients for their services, severely limiting the number of individuals who can access these services.[27]

While the prevalence of most insurance issues was consistent across insurance types, Medicaid patients had particular difficulty scheduling an appointment with a covered doctor. Medicaid patients were also more likely to report having poor health and the most likely to rate their insurance negatively.[28]

Doctor requests for Medicaid patients are also frequently denied by private insurance companies. Three-quarters of Medicaid patients receive their health services through private companies. These companies receive a fixed payment per patient rather than a payment based on the service provided. This system disincentivizes insurers from covering more expensive treatments because their reimbursement will be no greater. Doctors claim these denials (often accompanied by extensive paperwork) are interfering with their ability to provide Medicaid patients the care they need.[29]

The denials impact diverse communities the most. A July 2023 U.S. Department of Health and Human Services Office of Inspector General report on these denials and their effects stated:

> *People of color and people with lower incomes are at increased risk of receiving low-quality health care and experiencing poor health outcomes, which makes ensuring access to care particularly critical for the Medicaid population.*[30]

# 4. LACK OF TRANSPARENCY

Consumers, accustomed to knowing the price of a good or service before agreeing to purchase it, regularly shop around and choose to pay for the highest quality service they can afford at the lowest price they can find. This transparency and competition empowers consumers, raising quality and lowering prices. This benefit, however, is too often unavailable to consumers (i.e., patients) in today's healthcare system.

Lack of transparency in hospital pricing has long been a widely acknowledged problem. In 2021, the federal Hospital Price Transparency Final Rule went into effect. This rule requires hospitals to make prices and charges for 300 "shoppable services" publicly available (70 of which are specified). Yet compliance with this rule has been low. Prices for the same healthcare services continue to vary not only from hospital to hospital but sometimes even within the same hospital, and prices for patients who pay with cash are often lower than prices for patients who pay through insurance.[31]

It remains unclear whether this rule has effectively reduced hospital prices. Knowledge of prices before the rule is incomplete, making it challenging to establish price baselines. Furthermore, the widespread lack of compliance has prevented testing the theory that price transparency will reduce prices.[32]

Meanwhile, patients often think insurance companies, unlike hospitals, drive healthcare prices down. That is not always the case. *ProPublica* has reported that insurance companies, in fact, "often agree to pay high prices, then, one way or another, pass those high prices on to patients — all while raking in healthy profits."[33] It tells the story of a patient experience where "the hospital and insurance company had agreed on a price and he was required to help pay it. It's a three-party transaction in which only two of the parties know how the totals are tallied." The *ProPublica* report continues:

> *Patients who want to know what they'll be paying — let alone shop around for the best deal — usually don't have a chance. Before Frank's hip operation he asked NYU Langone for an estimate. It told him to call Aetna, which referred him back to the hospital. He never did get a price.*[34]

Like with hospitals and insurance companies, the lack of prescription drug price transparency plagues the PBM system. In HEC's 2023 report presenting policy proposals to help diverse communities, this organization noted:

> *PBMs work on behalf of insurance companies, negotiating large rebates from pharmaceutical manufacturers. These rebates, however, are not shared directly with patients, and these middlemen collect as much as half the spending on brand name medicines. The negotiated discounts, therefore, do not help vulnerable populations because they are not applied directly to consumers' out of pocket costs. In addition, a perverse incentive structure links higher priced drugs to larger rebates for the PBMs. This is particularly troubling since a large portion of PBM business is conducted with the federal 340B program, which was created to help hospitals that treat a disproportionately elderly or poor population.*[35]

PBM drug price discounts have risen dramatically over the years, driven by the consolidated power of the three largest PBMs. Yet the billions of dollars in discounts have not been passed along to consumers as lower drug prices. Instead, PBM intermediaries have pocketed much of the savings as profits. Because the details of these drug price negotiations are generally not known to the public, lack of price transparency here again results in higher prices, disproportionately harming diverse communities.[36]

**BECAUSE THE DETAILS OF THESE DRUG PRICE NEGOTIATIONS ARE GENERALLY NOT KNOWN TO THE PUBLIC, LACK OF PRICE TRANSPARENCY HERE AGAIN RESULTS IN HIGHER PRICES, DISPROPORTIONATELY HARMING DIVERSE COMMUNITIES.**[36]

# 5. INCREASED BUREAUCRACY

A July 2023 *New York Times* article sums up bureaucracy in the healthcare system well, describing it as:

> *[T]he space between the care that providers want to give and the care that the patient actually receives. That space is full of barriers — tasks, paperwork, bureaucracy. Each is a point where someone can say no. This can be called the administrative burden of health care. It's composed of work that is almost always boring but sometimes causes tremendous and unnecessary human suffering.*[37]

This administrative obstacle course can sometimes save costs for insurers, but can come at the expense of patient health, much like similar hurdles in accessing food security programs can leave families hungry.[38] Patients miss or skip needed treatments due to the confusion and frustration that administrative bureaucracy causes. Urgently needed care gets delayed. Work gets missed and wages get lost, leaving patients even less able to afford care.[39]

An August 2023 article in *U.S. News & World Report* described certain practices of the healthcare bureaucracy with additional specificity:

> *Hospitals and health systems are increasingly seeing commercial insurers limit patient access and issue more burdensome requirements for medically necessary care. Beyond prior authorization delays, for example, some insurers are expanding the use of so-called fail first policies, forcing patients to first try their insurer's preferred prescription drug treatment regardless of what a patient's doctors recommend. Others are restricting where patients can get covered care, such as by preventing some individuals from continuing to get their cancer infusion therapies from their long-standing providers and instead forcing them to go to new providers not connected to their care team.*[40]

**62%** **of respondents** reported that their household experienced at least one health insurance-related barrier to care in the past two years. Among those respondents, **43 percent said** their health had worsened as a result of that barrier.[41]

A December 2022 Morning Consult poll conducted on behalf of the American Medical Association found that 62 percent of respondents reported that their household experienced at least one health insurance-related barrier to care in the past two years. Among those respondents, 43 percent said their health had worsened as a result of that barrier. 86 percent of all respondents in this poll said they believe health insurance companies need to be more transparent about their coverage and the process for receiving it.[41]

The *New York Times* article further notes that the costs of bureaucratic health care are not distributed evenly, but rather inflict the greatest harm on diverse communities:

> *This burden falls most heavily on those who can least afford it: vulnerable people like cancer patients, those with complex medical conditions or those with a chronically ill child. I've observed that this burden splits along racial, ethnic and socio-economic lines. These tasks are more difficult for those who have hourly jobs, who don't speak English as their first language or who can't read complex documents easily. For many Medicaid patients, even just getting or staying enrolled in their insurance coverage can create hours of extra work that delay care.*[42]

# Policy Reform Considerations

## SOLUTIONS TAILORED FOR DIVERSE COMMUNITIES

The healthcare system needs numerous reforms to reduce costs and improve the quality of care. These reforms would address the corporatization of healthcare that has stolen decision-making power from doctors and patients through consolidation and complication. Certain reforms would particularly benefit diverse communities. These include bringing transparency to the PBM system, scrutinizing merger activity among insurance companies, hospitals, and PBMs, reforming the 340B program to help people afford the prescription drugs they need, and ending the harmful bureaucratic process that makes the cost of care depend on where the care is given—by requiring site-neutral payments.

# ESTABLISHING PBM TRANSPARENCY AND FAIRNESS

The Health Equity Collaborative has noted that PBMs are:

> *[T]hird party middlemen who determine the prices and coverage of prescription drugs for insurance providers, use rebate schemes to raise out-of-pocket prices for consumers and turn these exorbitant costs into their own profits. In recent decades, PBM manipulation has become a shadow boom industry.*[43]

Congress and the FTC have begun exercising oversight powers over PBMs, shedding light on anti-competitive practices conducted in the dark. Experts at USC Schaefer have suggested further reforms in drug rebate contracting, PBM transaction fees, empowering governments and employers with actual price transparency, and lowering the barrier of entry into the PBM market to add badly needed competition among PBMs.[44]

With similar goals in mind, the PBM Accountability Project proposes these PBM reforms:

- Require PBMs to report to businesses and state governments their actual cost for medicines they purchase
- Require PBMs to report all PBM revenue and its sources
- Ensure PBMs are paid transparent, competitive fees base on the value of their services
- Prohibit PBMs from profiting by manipulating the prices of prescription drugs
- Prohibit "steering," whereby consumers are required to purchase drugs through PBM-owned pharmacies
- Increase competition by allowing additional entities into the PBM market.[45]

These reforms – establishing transparency, prohibiting price manipulation, and increasing competition – would serve diverse communities by easing the financial burden of artificially high prescription drug costs.

# SCRUTINIZING INDUSTRY CONSOLIDATION

Hospital mergers have been a constant in the U.S. healthcare system for decades, particularly during the 1990s and 2010s. Despite theories and promises that hospital consolidation would lead to efficiencies that reduce prices for patients, costs have continued their steady rise. Some evidence suggests hospital mergers also result in worse health outcomes for patients.[46]

Over this period, legal efforts to block anti-competitive mergers have met with very little success. More is needed to stem the trend of hospital consolidation. First, there must be stricter, more thorough, and more widespread reviews of merger proposals. The FTC must be able to share all relevant information about a proposed merger with state and local authorities that are in stronger positions to challenge harmful – and possibly illegal – mergers.[47]

Further, the American Economic Liberties Project notes:

> *[State] legislators can pass laws mandating that any hospitals or other healthcare providers seeking to merge in their state inform the state attorney general's office. Unlike federal law, which only requires notification for large transactions, even small healthcare combinations can be threatening and should be subject. An example of such a measure is the Pennsylvania Open Markets Act or Washington state's notification system based on HB1607, both of which require nearly all healthcare transactions to be reported to the state attorney general and for any healthcare merger notifications provided to the Federal Trade Commission to be shared with the state attorney general.*[48]

Additional reform options include:

- Empowering state attorneys general could also be granted greater power to enforce antitrust laws.
- Eliminating exemptions for hospitals from antitrust laws, such as those that grant an exemption in exchange for greater merger oversight (certificate of public advantage – often referred to as COPA – laws). Greater competition among hospitals would serve patients better than government oversight that is unable to prevent consolidation.
- Repealing certificate of need (CON) laws that promised to eliminate waste and duplication but in practice have facilitated anti-competitive hospital consolidation.
- Ending exemptions to antitrust laws for nonprofit hospitals, as consolidation of these hospitals, too, harms patients.
- Creating a new task force on hospital mergers that could empower the FTC with historical and other evidence it can use to challenge proposed mergers.

Actions like these, which would reverse longstanding trends toward hospital monopolies, would force hospitals to provide higher quality care at a lower cost. Diverse communities that are least able to afford high prices, and that often receive the lowest quality care, would benefit from this increased competition.

# FIXING THE BROKEN 340B PROGRAM

As has been noted in a prior section, the 340B program is frequently abused by hospital participants that profit at the expense of the very underserved communities the program is intended to serve. This occurs when savings from program discounts on prescription drugs are neither passed on in the form of lower drug prices or reinvested in the designated community's healthcare system to improve quality of care. To address these abuses, ASAP 340B offers these straightforward reforms:

- Require all "covered entities" (i.e. hospitals and other healthcare centers) participating in the 340B program to regularly report how their 340B savings are being used to benefit the communities they serve.
- Require entire hospital systems to reinvest 340B savings to benefit the 'home base' communities they serve. Many hospitals create satellite service centers that receive 340B drug discounts but cater to populations with higher rates of private insurance (that pays higher prices for drugs). These same hospitals often reduce services at the very location that allowed them to qualify for 340B benefits in the first place. Thus, hospitals game the program to maximize profits at the expense of the underserved communities that make their profits possible. This reform would counter that harmful practice.
- Protect patients in underserved communities from unfair, overly aggressive medical debt collection practices.[49]

With these 340B reforms in place, diverse communities would experience real benefits in the form of higher quality, more available care.

# REQUIRING FAIR, SITE-NEUTRAL PAYMENTS

With Medicare patients, healthcare providers today are allowed to charge different rates for the same services when those services are performed at different locations. Hospital outpatient centers, for example, may charge more for a particular service than a doctor's office. This has led to hospitals buying out physician practices and labeling them 'outpatient centers.' As these buyouts occur, costs at these former physician practices increase. Not only does this drive up costs for some individual patients when they see their doctors, it also puts added financial strain on the entire Medicare system, which must account for the higher payments.[50]

Requiring site-neutral prices and payments would end this incentive (or loophole). In Congress, one proposal would eliminate the exemption allowing some hospital outpatient departments to charge higher rates even if the department is not located at a hospital. Another reform proposal would reduce Medicare reimbursement rates for hospital services that can be routinely performed in a doctor's office.[51]

These types of reforms – and others moving toward a site-neutral payment system – could save the Medicare program tens (possibly hundreds) of billions of dollars. They could also put downward price pressure on private health insurance. This is because reducing hospital purchases of physicians' offices would allow those offices to maintain a stronger negotiating position with insurers.[52] Downward price pressure would therefore help diverse community members who use either Medicare or private insurance.

Given the political power of hospitals, however, proposals like these will likely face strong resistance. As a compromise, some savings from reforms like those mentioned above could be returned to hospitals experiencing large drops in Medicare revenue. Alternatively, reimbursement formulas could be more precisely pegged to actual costs. A third option for addressing hospital concerns would be allowing some increases in payment rates elsewhere in the system to help mitigate costs to hospitals of a site-neutral payment policy.[53]

# ENSURING PATIENTS ARE PROTECTED FROM UNEXPECTED MEDICAL BILLS

In December 2020, the No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021. The NSA was intended to protect patients from "surprise medical bills" when patients unknowingly obtain medical services from providers outside of their health insurance network.

Patients expected some relief when the law went into effect on January 1, 2022, however, implementing the law has proved challenging giving rise to complex compliance problems that will ultimately harm patients if left unresolved.

According to a recent report by the Commonwealth Fund:

> *Enforcement is a particular challenge. Consumer complaints are critical for identifying compliance issues because there is no systematic way for government agencies to track incorrect bills. The federal government will receive complaints through a federal portal and phone line. In the spirit of this "no wrong door" policy, complaints also may be received by state insurance departments. Ideally, complaints will be routed quickly and efficiently to whatever state or federal agency can best investigate and address them. Many believe that informal contacts to a noncompliant insurer or provider will resolve most complaints.*
>
> *It will be important to monitor these efforts to learn how well and how quickly complaints are resolved and how often they must be elevated to a more formal enforcement process. For example, the U.S. Department of Labor lacks a track record for effective oversight of self-funded plans. And many states lack any history for enforcing requirements on facilities and providers with regard to billing issues.*[54]

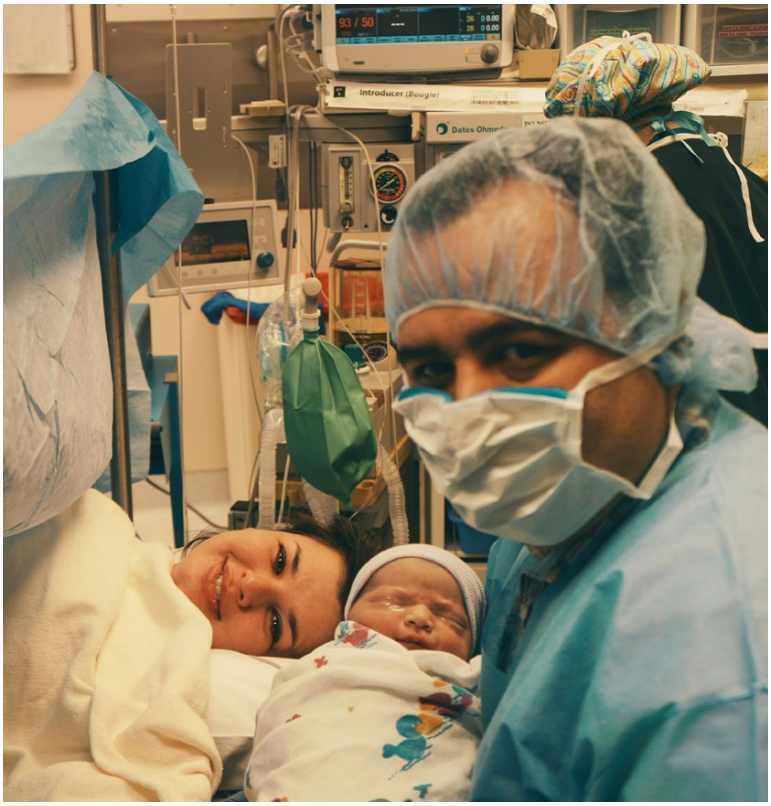

While the government continues to implement enforcement practices, insurance companies are taking advantage of the moment. There are a growing number of reports about insurers refusing to pay awards through the independent dispute resolution (IDR) process, the federal system for resolving payment disputes between insurers and providers.[55]

In addition to refusing to pay medical providers following an IDR process resolution, insurance companies have also sent bills directly to patients with a letter explaining that the NSA's directive is "unenforceable" and "not binding."[56] This is a growing problem. Although the NSA has been the law for more than three years, 52 percent of patients did not receive arbitration-determined payments from insurers.[57]

**ALTHOUGH THE NSA HAS BEEN THE LAW FOR MORE THAN THREE YEARS, 52 PERCENT OF PATIENTS DID NOT RECEIVE ARBITRATION-DETERMINED PAYMENTS FROM INSURERS.[57]**

To ensure that policymakers are protecting patients and fulfilling the intent of the law, such practices must be addressed. To date, complexity, costly administrative processes, and ongoing financial games remain prevalent and threaten the ability of patients to both access and afford the care they need.

# Conclusion



Disadvantaged, diverse populations suffer the most from deep flaws in the U.S. healthcare system. The largest problems with the system revolve around excessive consolidation, lack of transparency and competition, and bureaucracy that allows the gaming of programs intended to help disadvantaged communities. Thus, policy solutions that add transparency, competition, and accountability, while eliminating harmful exemptions and loopholes, would have the greatest benefit for diverse populations while improving the U.S. healthcare system as a whole. Combined with policies that address social determinants of healthcare[58] and expand diversity across the entire healthcare system,[59] these reforms would make the U.S. healthcare system a far more equitable one.

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