UNLOCK™
Managed Care

What to expect in 2025

MANAGED CARE TRENDS
AND PREDICTIONS

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A moment of reflection before we begin

Any discussion of managed care trends and predictions must take note of the tragic murder of Brian Thompson, CEO of UnitedHealthcare, just a few short months ago. Once upon a time, it seemed that the healthcare system was built for physicians, not patients. Now the healthcare system in this country is undeniably built around the needs of insurance companies. It's certainly not serving healthcare providers or their patients. That's why we spend our lives working with healthcare providers to battle the unreasonable and irresponsible policies they implement. Yet, as strongly as we may feel, and whatever righteous indignation we may experience, violence is never the answer.

As Dr. Martin Luther King, Jr. said, "In spite of temporary victories, violence never brings permanent peace." Even as UnitedHealth Group leaders mourned Brian Thompson, they set the stage to continue the policies that inspired such a frightening response from the public at large. We must achieve lasting change through conversation, negotiation, and understanding. In spite of media predictions in the aftermath of the murder that change must surely come, the road ahead is long. Insurers have too much money, too much power, and too much political influence to acquiesce quickly.

In this report, we cover six key areas to watch in 2025 and beyond:

- Site-neutral payment policies
- Hospital and health system consolidation
- The expansion of artificial intelligence
- Increasing administrative burden on healthcare providers
- Medicare Advantage
- Contract language and terminations

In addition to work happening at the state and local level, national changes are likely. The inauguration of a new presidential administration and sweeping changes in the makeup of Congress have the potential to make this year one to watch closely. At Unlock Health, we plan to do just that. And we will help our provider clients level the playing field wherever possible - maybe we can tilt it in our favor from time to time.

Brandon Edwards

Kevin Thilborger

Site-neutral payments

You fund an ER and transplant program — are your costs the same as an ASC?

Expect expansion from Medicare into commercial markets

The first significant legislation proposing site-neutral payments in Medicare was the Bipartisan Budget Act of 2015. Since then, the quest to expand the scope of site neutrality has continued, finding success in the House of Representatives but languishing in the Senate. That could change with a reconstituted House and Senate in the new Congress.

In late 2024, a new legislative framework included two provisions that represent the latest attempt to expand site neutrality in Medicare claims payment. The first removes the grandfathered exemptions for existing off-campus outpatient departments. The second broadens the scope of site neutrality to encompass procedures performed in on-campus hospital outpatient departments. It also attempts to remove previous objections related to lost revenue for rural and safety-net facilities, many of which are already in danger of closing.

"Common sense" based on flawed assumptions

The reason site-neutral payment legislation continues to appear, and to garner bipartisan support in the House, is that projected savings are eye-popping. A move to fully site-neutral Medicare payments would potentially save the federal government $150 billion and save beneficiaries an additional $100 billion in reduced premiums and out-of-pocket expenses.[1] For a program that's responsible for 27% of the federal budget deficit, legislators can't afford to look like they're leaving money on the table.[2] Of course, 100% of those dollars come out of the pockets of hospitals and health systems with no offsets of any kind.

Site-neutral Medicare payments are often described as common-sense policy. After all, proponents argue, a service should cost the same regardless of where it happens. In fact, Beckers reports that, "On average, Medicare rates for ASCs are 50% of what HOPDs receive for the same services," according to the Ambulatory Surgery Center Association.[3]

The reality is that nothing costs the same regardless of where it happens. The cost of a loaf of bread in Buffalo, New York is around $3.50 whereas the same loaf costs over $4.00 in Manhattan, and it might be $5.00 or $5.50 in Hawaii or Alaska.[4] The same bread in the same package costs the consumer more because the stores that are selling it have different costs.

Comparing bread costs across the U.S.

The American Medical Association said in Beckers:

> "The AMA does not believe it is possible to sustain a high-quality healthcare system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. Additionally, the AMA urges CMS to pay physicians fairly for office-based procedures and, where clinically appropriate, shift more procedures from the hospital to office setting, which is more cost-effective."[5]

Comparing the administrative costs of providing care in a full-scale hospital versus an ambulatory surgery center versus a physician's office isn't comparing apples to apples. It's more like comparing apples to oranges to kiwis. They're all fruit, but they're fundamentally different. And the impact of healthcare access is a heck of a lot more important than fruit.

The other basic flaw in the "common sense" argument for site neutrality is that healthcare isn't bread. It's highly specific based on the clinical presentation of the patient. Where options exist, site of service decisions are a matter of clinical judgment. Higher risk patients generally receive care in hospital-based settings because they're best equipped to address any adverse events that occur during the course of a routine procedure when people have complex issues. Ultimately, the services may not be needed, but there's a cost associated with ensuring they're available. And if they're needed, they aren't optional — they're essential.

To quote the American Federation of Hospitals (AFA), "This one-size-fits-all payment ignores the fundamental functional and cost structure differences between hospitals and physician offices — among other settings — and threatens the unique, mission-critical services that communities rely on hospitals to provide 24/7/365."[5]

Added burden to already over-burdened systems

Make no mistake, private payors are watching what happens in the Medicare space related to site neutrality, and they're not being shy about it. David Merritt, Blue Cross Blue Shield's senior vice president of policy and advocacy wrote:

> "Medicare's move to expand site-neutral payments would pave the way for private insurance plans to also implement these payment policies, ultimately increasing access to high-quality and affordable care."[5]

This would be a disaster for hospitals and health systems everywhere.

Multiple payors have tried to implement a portion of this in the past, for example, paying for outpatient radiology services at the independent diagnostic facility (IDTF) rates. In one system where we reviewed this, the change was going to reduce payments to that organization by almost $90 million. Other payors are implementing policies for endoscopies and other services that can be performed at multiple different facility types. We must be prepared with analytics as well as

PR and marketing strategies to protect from these types of payor behaviors.

The vast majority of patients have government-sponsored or private commercial insurance, so when it comes to hospitals feeling a budgetary pinch, lack of coverage isn't the issue. In spite of the picture payors paint of providers trying to inflate their bottom lines, the reality is they need to be able to cover the basic costs of delivering care.

As the cost of materials, wages, and employee benefits have increased for providers, payors have pushed for stable or lower payment rates. To protect their financial futures, hospitals large and small will be forced to attempt to renegotiate their payment rates for inpatient services. Maintaining existing payment rates as the costs of materials and employee wages and benefits increase is simply not tenable. Yet cash-strapped health systems often lack the leverage needed to improve their payor contracts given the possible disruption that can accompany a tough negotiating posture.

PREDICTION FOR 2025

Payors will continue to prioritize savings over common sense

Whether insurer or provider, all revenue can be distributed into categories reflecting the pure cost of care, administrative expenses, and profit. The health insurance industry spends weeks every year calculating and reporting their MLR, adjusting administrative costs as needed to protect their profits. They cannot expect their provider partners to indefinitely operate at a loss so they can continue to post billions of dollars of profit annually.

Payors are positioned to follow CMS's lead on site neutrality, all in the name of protecting the healthcare consumer from the rising cost of care. Providers will then seek to increase their payment rates for inpatient services to offset the reduction in outpatient revenue. They have to in order to maintain their operating budget. And when this all comes to pass, there's no doubt who payors will cast as the villains in that piece.

Mergers & acquisitions (M&A)

It's a conflict of interest to own everything?

Expect to see continued consolidation and less regulation

A study released by the Yale Tobin Center for Economic Policy in April 2024 looked at more than 1,100 acute-care hospital mergers that happened in the U.S. between 2002 and 2020. In it, the authors conclude that 20% of the mergers resulted in less competition. Further, those "anticompetitive" mergers allegedly resulted in a 5% increase in costs.[6] The authors concluded that that there is a lack of FTC oversight in the healthcare arena and that more deals should be scuttled going forward.

Right math, wrong conclusion

Though the math in the study might be correct, the underlying assumptions it proves are wrong. The authors are the latest to join a globally recognized research firm using payor data to try to promote healthcare cost transparency. This is the root of the problem.[7] Payors are singularly focused on keeping contracted payment rates stable or lower. At the same time, healthcare providers are experiencing exponential increases in costs related to materials, wages, benefits, and health technology. Of course they need higher payments from payors, and it's ludicrous to suggest that they don't.

The real problem: keeping doors open

As a counterpoint to the merger rate, let's look at the hospital closure rate. Between 2010 and 2023, more than 130 rural hospitals closed their doors.[8] In 2024, the University of Pennsylvania's Leonard Davis Institute of Health Economics (LDI) brought together experts to discuss the state of rural healthcare in America. In her opening, LDI Executive Director, Rachel M. Werner, MD, PhD, said:

> "Since 2005, more than 190 rural hospitals have closed across the United States, and many more are in danger of closing because of financial shortfalls. This problem is only getting worse, with a recent report finding that half of rural hospitals lost more money in the past year, up from 43% in the previous year."[9]

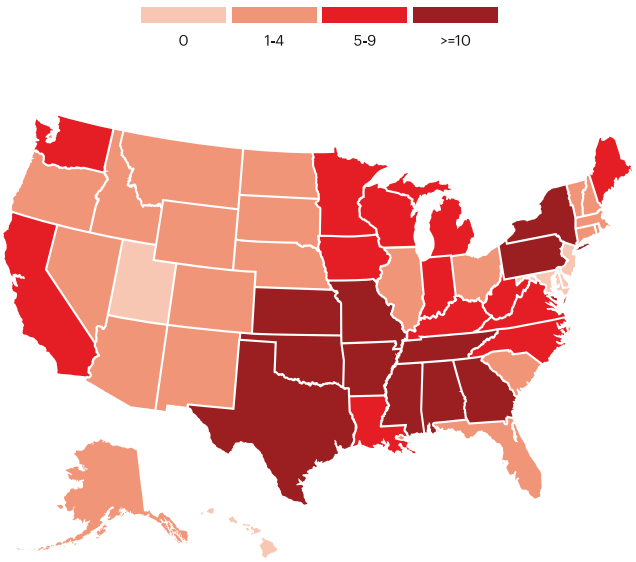
Harold Miller, MS President and CEO of the Center for Healthcare Quality and Payment Reform went on to say:

> "The reality is that it's low payments from private insurance plans that are causing the problem in rural hospitals. There's a widely held belief that both large and small hospitals get higher payment from private insurance plans than Medicare and Medicaid. But the exact opposite is true for a lot of small rural hospitals."[9]

Another challenge facing rural hospitals is the bypass effect. Qualitative studies show that 50% or more of patients leave their communities to seek care at larger facilities.[9] The perception, whether real or imagined, is that city hospitals offer a wider variety of services and achieve better health outcomes. Yet rural hospitals provide critically important emergency services.

Fewer patients seeking care. Insufficient payments for services provided. It's no wonder that 30% of rural hospitals in the U.S. are in danger of closing permanently.[10] As 80% of rural America is already medically underserved, additional closings of this magnitude would be devastating.[11]

Rural hospitals at immediate risk of closing



Source: Center for Healthcare Quality and Payment Reform

Together, for better or worse

There are several ways to approach consolidation.

+ **Horizontal M&A** allow parties offering similar services to come together to expand their capacity and reduce administrative costs. The early days of the Affordable Care Act saw a lot of this kind of activity in the payor space. Smaller regional carriers were snapped up by larger carriers as they struggled to thrive under MLR constraints. That's why today we find ourselves with the majority of members held by just five insurers — with UnitedHealthcare far outstripping its competitors when it comes to market share by revenue.

+ **Vertical M&A** allow parties to close perceived gaps in services. UnitedHealth Group has been not-so-quietly using vertical M&As to get around MLR constraints for years. By purchasing physician practices in its Optum division, UnitedHealth Group has created an in-house network of providers to serve members insured by UnitedHealthcare. In fact, United is now the single largest employer of physicians in the United States. And more than 50% of United's corporate profit is derived from its PBM, OptumRx.

  This synergy allows UnitedHealth Group to collect the MLR-sanctioned profits from insurance premiums as well as profits from paid claims. To add to this, it means they can pay their employed physicians more than any health system or independent physicians. Then, UnitedHealthcare can negotiate aggressively with the non-employed physicians ultimately making them less financially stable and ripe for acquisition. It's diabolically clever — or just diabolical.

+ **Cross-market M&A** are exactly what they sound like. They offer parties operating in separate geographic footprints to come together to expand their reach. These tend to have less regulatory impact. Because the parties don't compete with each other, the competitive landscape in each individual market is largely unaffected.

The American Hospital Association asserts that data "reinforce[s the] conclusion that hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost." It shows a reduction in expenses per admission. It also shows a reduction in 30-day mortality and readmission rates for heart attack, heart failure, and pneumonia — all key hospital quality measures.[12]

An integrated health system, especially one that extends the reach of a highly respected brand, can be a boon for consumers and communities. Patients no longer have to travel to feel as if they're getting better quality care. And communities may benefit from economic investment and health outreach initiatives that advance a larger organizational mission as well as improved benefits, pay, and education.

PREDICTION FOR 2025

Market forces, especially continued bad behavior from payors, will continue to drive provider consolidation.

Maintaining healthcare access and quality are key initiatives, especially as the U.S. population continues to skew older. Healthcare providers face significant headwinds:

- Contracted rate increases continue to be below inflation and the payments often fail to cover the actual cost of providing care
- Administrative obstacles to contractually owed payments create additional provider costs — staffing, systems, and the time value of money
- Staffing shortages continue to make recruiting and retention highly competitive

It doesn't appear likely that the second Trump administration will turn a closer regulatory eye to hospital acquisitions as called for by the authors of the Yale study. In general, President Trump tends to be more business friendly. It also looks like "fixable deals" will be back on the table. In that environment, parties to a merger can address the regulator's objection without abandoning the deal in total.

Finally, Federal Trade Commissioner (FTC) Melissa Holyoak said in an October 2024 webinar hosted by George Mason University's Mercatus Center, "I would strongly consider rescinding or revising" merger guidelines issued jointly by the FTC and Department of Justice (DOJ) in 2023.[13] In lieu of closer attention from federal antitrust regulators, challenges would need to come from state Attorneys General.

Meanwhile, I leave you with these questions.

1. If it's not acceptable to the FTC and DOJ for any hospital system to own more than 50% of the beds in any one geography, why is it acceptable for a health insurance company to represent more than 50% of the commercial lives in a given market? Especially when that's the only profitable business that providers serve.

2. At what point do we consider a company that owns the largest of every outpatient service a monopoly or a problem?

3. Do you approve of venture capital or private equity owning physician practices? If not, should for-profit publicly traded entities be allowed to do so? Where, if anywhere, should government draw the proverbial line?

Artificial intelligence (AI)

AI — so far so good ... for payors

Expect accelerated adoption of AI by payors

Like every other industry, health insurance benefits greatly from improvements in technology, but adoption takes time. The concept of electronic data interchange (EDI) for claims submission, appeared in the 1960s, yet the industry wasn't quite ready for it. Technology costs were high, as were gaps in security, and standardization was low. It wasn't until computers really caught on in the 1970s and 1980s that EDI gained traction.

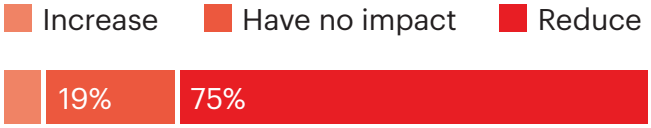
Today, administrative costs related to billing and processing are lower, accuracy is higher, interoperability between providers and payors is better, and the revenue cycle is faster. Though there have been improvements in standardization and data security, the industry has not faced another technological tipping point until the introduction of AI.

AI has awareness, but not trust

A survey by Bentley University and Gallup showed that more than 60% of Americans describe themselves as at least somewhat aware of AI, but there's a clear crisis of trust from that point.[14]

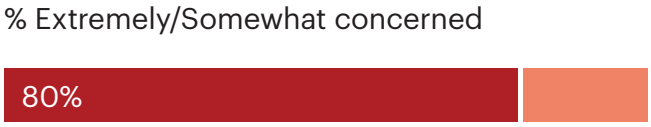
- 75% think AI will reduce the number of jobs in the U.S.[14]
- 77% don't trust businesses to use it responsibly[14]
- 80% are concerned about AI recommending medical advice[14]

What type of effect will AI have on the total number of jobs in the U.S. over the next 10 years?



In general, how much do you trust businesses to use artifical intelligence responsibly?

How concerned are you about artificial intelligence being used to recommend medical advice?



Source: Bentley University and Gallup poll [14]

The American Medical Association (AMA) issued a press release in late 2023 addressing principles for the development and use of AI in healthcare. In it, AMA President Jesse M. Ehrenfeld, MD, MPH is quoted as saying:

> "The AMA recognizes the immense potential of health care AI in enhancing diagnostic accuracy, treatment outcomes, and patient care. However, this transformative power comes with ethical considerations and potential risks that demand a proactive and principled approach to the oversight and governance of health care AI.
>
> The new AMA principles will guide the organization's engagement with the administration, Congress, and industry stakeholders in discussions on the future of governance policies to regulate the development, deployment and use of health care AI."[15]

The principles set forth by the AMA call for oversight, transparency, and documentation as well as adherence to patient privacy and data security regulations. The principles also recognize that while healthcare providers see opportunities in the use of AI, payors do as well. The AMA urges that as payors use AI and algorithm-based decision-making streamline administrative processes, they take steps "to ensure that these systems are not overriding clinical judgement and do not eliminate human review of individual circumstances."[15]

Payors aren't off to a good start

ProPublica and The Capitol Forum published a scathing article detailing how Cigna used an algorithm, PXDX, to match procedure codes with select diagnosis codes. If the codes didn't match, the claims denied as "not medically necessary" with an apparent rubber stamp from company medical directors. The report showed that Cigna denied 300,000 claims in just two months, with an average review time of less than two seconds per claim.[16]

In a Congressional review of Cigna's practices, Representative Cathy McMorris Rodgers noted that Cigna's Medicare Advantage members only appeal one in five denials with an overturn rate of 80%.[17] She wrote, "If these figures are at all illustrative of Cigna's commercial appeal and reversal rates, it would suggest that the PXDX review process is leading to policyholders paying out-of-pocket for medical care that should be covered under their health insurance contract."[17] Is it acceptable to be wrong almost 80% of the time? Who wouldn't be fired for that other than a meteorologist?

Insurance behemoth UnitedHealthcare, its parent company UnitedHealth Group, and AI developer NaviHealth found themselves named in a class-action lawsuit alleging that UnitedHealthcare used an AI model with a 90% error rate to deny care as not medically necessary.[18] UnitedHealthcare insists the model is simply a tool used by medical directors to inform coverage decisions. Plaintiff attorneys counter that UnitedHealthcare is saving money because "only a tiny minority of policyholders (roughly 0.2%) will appeal, and the vast majority will either pay out-of-pocket costs or forgo the remainder of their prescribed post-acute care."[19] Multiple studies have shown that patients are forgoing the additional prescribed care. Who is paying the bill? Everyone but the insurance carrier.

Don't give up hope

Payors may be off to a rocky start with AI, but there's still a lot of potential for good. What if, instead of having teams of nurses checking prior authorization requests against InterQual criteria, AI models did the work? Practice software could be optimized to assure that all required documentation is present in the request before it goes in. AI models at the carrier could double-check the submission and generate approvals in seconds rather than days. AI models could also empower revenue cycle teams to spend time on trends and not working on singular claims.

As the Gallup poll reflects, people have been concerned about machines taking over the work of people since the start of the industrial revolution. Yet, there are inherent opportunities if we choose to see them. Healthcare providers and patients both benefit from faster, more accurate claims processing, real-time benefit eligibility, and faster exchanges of information that EDI fostered. Responsible deployment of AI models in eligibility, prior authorization, and revenue cycle could be beneficial as well. If insurance companies are going to continue to require prior authorizations for things that are easily adjudicated, then let's allow the machines do it. Are so many people clamoring for excessive colorectal cancer screenings that we need prior authorization to ensure a colonoscopy is medically necessary? The American Cancer Society doesn't seem to think that's the case.[20]

Let's give clinicians time to review cases that are complex or unclear. Machines do many things well, but you can't beat clinical experience and intuition when it comes to healthcare — at least not yet. Sometimes, a few follow up questions from a nurse to a provider's office is enough to obtain approval. Sometimes, medicine is a balance of art and science, and it takes a peer-to-peer conversation to understand the full clinical picture. Responsible use of AI should allow for medical directors and nurses to spend time reviewing those more complex cases and actually speaking to the prescribing physician.

PREDICTION FOR 2025

AI will continue to expand in scope, but regulations may have a hard time keeping up.

Payors argue that they've been using AI tools for years. Machine learning models are hard at work for patients identifying gaps in evidence-based care that are shared with providers. They're improving the member experience, paying claims faster, and helping to uncover fraud. Ultimately, however, it's the user that decides how any tool is used and what information it uses to do its work (garbage in, garbage out). It may be true that up to this point, payors have been using machine learning to improve clinical outcomes and enhance the patient experience. However, recent events show that there is potential for real harm when AI is used incorrectly.

Health insurance oversight is a murky business. Fully insured commercial policies are subject to state regulation. Government programs are regulated by the funding agency, states for Medicaid, the federal government for Medicare. Self-insured employer plans are subject to ERISA as well as some state laws. Some states, like California, are passing laws prohibiting insurers from denying coverage based solely on AI algorithms.[21] Yet there aren't enough states making regulatory progress in this area. If there was ever a time for us to abandon the patchwork approach to insurance regulation, this is it. Can we really trust an industry that has shown itself willing to behave badly in myriad ways to police itself when it comes to an incredibly powerful and evolving technology?

Administrative burden

What do you mean you need more time for patient care?

Expect more of the same in 2025 and more … and more

Beyond the time spent face-to-face with patients, providers need to keep clinical records, research treatment options, and complete mounds of billing paperwork. This integral work could be optimized in many ways to keep administrative costs in check. However, insurers have done their utmost to add to the administrative burdens facing healthcare providers. And they have the audacity to claim they're doing it in the best interest of patients and to control the cost of care.

The mysterious case of vanishing providers: access to care

The No Surprises Act (NSA), effective for three years, requires insurers to update and verify provider networks at least every 90 days. That we even need to have this codified in law seems ridiculous. Who benefits from incorrect information in provider directories? It leads to frustration on the part of patients and providers, and it results in rework when claims are processed incorrectly. It's a billing nightmare. Yet provider directories remain inaccurate, insurers know it, and enforcement is minimal or nonexistent.

We did our own healthcare provider searches in Chicago in 2024. The first 11 podiatry providers, all the chiropractors in the first two pages, and 50% of another specialty in the network directory were a mess. The office address was incorrect, (not just the suite number) it was closed entirely, or the doctor wasn't affiliated with the group listed.

Further, in 2022 and 2023, the New York state attorney general's office called hundreds of mental health providers listed in directories from more than a dozen health plans. Results showed, "86 percent of the listed, in-network mental health providers staff called were ghosts, as they were unreachable, not in-network, or not accepting new patients."[22]

Authors of the report went on to say, "These results are shocking but not surprising, as they confirm what testimony, complaints, and surveys suggest: in-network mental health care is inaccessible to many New Yorkers who need it."[22] These are people at their most vulnerable. It's not the time to start a game of who's in the network, and it's irresponsible to advertise a robust provider network that is complete fiction. This is what happens when laws are vague, not enforced, and lack significant penalties for noncompliance.

David Lloyd, Chief Policy Officer of Inseparable, a mental health advocacy group, was quoted by ProPublica as saying, "You can have all the strong laws on the books. But if they're not being enforced, then it's kind of all for nothing."[23]

Even when it is being enforced, is it getting to the root of the problem? It's one thing to choose to see a provider who's not in the network and proceed based on an honest estimate of out of network costs. Though one could argue that not having a sufficient network in which to seek care removes some of the element of choice.

Given the real-time nature of electronic transactions today, it's not unreasonable to expect insurers to get their houses in order. Yet complaints to CMS about violations of the NSA are overwhelmingly about providers, not health plans — by about 6 to 1.[24] When are we going to start holding payors responsible for these disconnects instead of providers?

A question of medical necessity: outright denials and unnecessary reviews

Denials: Kudos to California for enacting a law that's designed to bring bot-based denials to an end — may it be the first of many states to do so. Before bots could turn the prior authorization process into complete chaos, people had to teach them what to do. Bureaucrats targeted inpatient stays beyond targeted lengths and treatment outside specific criteria as prime fodder for AI models.[25] Whether initiated by bots or humans, denial rates are skyrocketing. Denial rates for commercial claims rose over 20% between 2022 and 2023, and a whopping 56% for Medicare Advantage claims.[26] Insurers know that the vast majority of denied claims don't go through the appeals process.

In late 2024, Anthem Blue Cross Blue Shield, a subsidiary of Elevance, planned to limit

coverage for anesthesia in surgeries and procedures that went on too long, according to their interpretation. Given the sophistication of analytics and predictive models available to the industry, there are better ways to identify and curtail overbilling. Insurers should be reviewing the research — it's out there — and checking trends in their claims data. Instead, they put the burden of proving claims are valid on the majority of innocent providers.

Anthem rolled back the announcement almost immediately after intense comments from furious anesthesiologists, an outraged media, and a generally befuddled public. Sadly, it only garnered this level of attention because people were following the insurance industry after Brian Thompson was murdered. Reporters actually talked about it. Can you imagine if they covered every ridiculous payor edit or policy? We might actually have a functioning set of insurance partners.

Prior authorization: The argument for utilization management from a payor perspective is "right care, right time, right place." It's supposed to ensure members receive medically necessary care in a timely fashion in an appropriate place of service. In reality, prior authorizations are more accurately described as a way to control costs. The more expensive or experimental a procedure is, the more likely it is to require approval from insurers. The whole process undermines the expertise of medical professionals and can delay care in ways that cause irreparable harm to patients.

In its annual prior authorization survey of 1,000 practicing physicians, the American Medical Association found that:

- 78% reported patients abandoning recommended courses of treatment[27]
- 94% said prior authorizations delay patients' access to necessary care[27]
- 19% said delays resulted in a serious adverse event and hospitalization[27]
- 13% said delays resulted in a life-threatening event with potential for permanent impairment or damage[27]
- 7% said delays lead to a patient's disability, permanent bodily damage, congenital anomaly, birth defect or death[27]

About 10% of prior authorization denials go through the appeals process, but when they do, the overturn rate is above 80%.[28] Clearly, the vast majority of delays are entirely unnecessary. This is exactly why American consumers have little faith in the healthcare system in this country.

Prepayment reviews: Optum had to suspend prepayment reviews (PPR) for mental health claims. These had created unnecessary administrative and financial pressure on providers at a time when the U.S. is experiencing a dramatic rise in mental health conditions.

A joint letter from the American Psychological Association and American Psychiatric Association to Optum CEO, Dr. Amar Desai, said, "We have numerous reports from our members, as well as media reports, of Optum patients stopping mental health treatment because of fears that Optum will not reimburse them."[29] It went on to say:

> "Many members were already reeling from months of not getting reimbursed from multiple insurers due to the massive cyberattack on the part of Optum that is Change Healthcare. Optum adding further cash flow problems on the heels of the Change Healthcare payment stoppage is outrageous ... In the Psychologists Survey, 44% of respondents (to a question about provider impacts of the reviews) had concerns about whether the PPRs would impact their ability to stay solvent."[29]

Optum plans to reintroduce this policy once providers "are aware of the company's documentation expectations well in advance of further reviews."[30] Why? Where is the documentation that these barriers stopped inappropriate care? Do they really need "all medical records that support the services" to process a claim for an office visit? Where are all the studies and results with reams of data that show that all these patients were seeking care they didn't need?

An uneven exchange: timely claims filing without timely payment

All payors have timely filing requirements for claims. It's a critical component for financial models related to the claim payment reserves that states require to demonstrate solvency. Payors ruthlessly enforce timely filing, even in situations where coordination of benefits makes it unclear who the primary payor should be. The minute a claim is late, it's denied, denied, and denied again. For all the rigor payors follow in accepting claims, they demonstrate little when it comes to paying them.

The Change Healthcare cyberattack in February 2024 exposed PHI for 100 million Americans, disabled claims submissions, and created a revenue nightmare for providers throughout the U.S. As of December 2024, providers were still being notified that their patients' data was compromised in the attack. The extent of damage done has yet to be determined, but Nebraska Attorney General Mike Hilgers knew enough to file a lawsuit against Change Healthcare. He is undoubtedly the first of many.[31]

The issue of timely claims payment precedes the Change Healthcare attack by years, if not decades. Some payors have a reputation for violating prompt payment laws with impunity for years. One carrier collecting premiums from more than 2.5 million members has infuriated California providers for years,

generating countless complaints from providers and associations. Regulators have only recently started to review the problem. But they're hardly alone, prompt payment laws give payors, on average, 90 days to process and pay a clean claim. Technology should be reducing the amount of time it takes to process and pay claims. Instead, it took almost 20% longer for commercial payors to process hospital claims in 2023.[26]

Interestingly enough, with all its flaws, traditional Medicare is generally the fastest payor. With all the investment commercial payors have made in streamlining the electronic submission and payment process for claims, good old Medicare is the fastest payor. How can that be? How is it possible that commercial payors have not caught up? It's definitely not a matter of actually having the money to pay claims. Commercial insurers booked tens of billions of dollars in profit in 2024, and self-funded clients generally have the assets needed to pay claims in a timely fashion. The ability to pay is not in question. Instead, it appears that delayed payments are a means to retain funds as long as possible.

PREDICTION FOR 2025

All signs point to payors stubbornly adding to administrative burdens, and providers aren't here for it.

A Kaiser Family Foundation survey showed that about 90% of insured adults want insurance to be easier to understand and use.[32] Specifically, they support:

- Accurate and up-to-date provider directories — no more ghost providers or providers with zero capacity for new patients
- Simpler, easier-to-read explanations of benefits — a quick scan of one from BCBS of Illinois immediately shows why that's needed
- Advance confirmation from the insurer of coverage and cost of care — coverage is set by insurers, so they should offer the estimates
- Transparency related to claims denial rates — if denials are reasonable and responsible, why not share the statistics

None of this seems unreasonable. Yet the insurance industry seems determined to treat the appeals process as a natural extension of normal claims processing. According to the American Hospital Association, about 15% of claims submitted to private payers get denied — even if there is a prior authorization in place.[33] For providers, going through the appeals process is resource intensive and lengthens the revenue cycle, but at least most know their rights. Almost 70% of insured consumers don't know what their appeal rights are, something the insurers are well aware of.[34]

Continuing to add to already onerous administrative processes is only going to alienate providers and create anxiety and care delays for consumers. We are keeping a running list of health systems that are cutting their losses and dropping the Medicare Advantage contracts that pay them significantly less than traditional Medicare. Losing network providers means consumers will wait longer to receive care and have less face-to-face time with providers. If insurers want to sustain viable networks, they'll need to buy provider practices and steer members to ever-narrower networks of physicians, surgery centers, and ancillaries they own. Oh, wait...

Medicare advantage (MA)

Whose advantage is it exactly?

Expect continued enrollment growth and a more friendly regulatory environment

We wrote extensively about MA in 2024, and all signs point to it being an area to watch closely in 2025. Immediately after the election, most insurers offering MA plans saw a bump in their stock prices. **Humana**, which announced in 2023 [35] that it would leave the employer-based market and focus exclusively on government-funded programs, shot up more than 10%.[36] Clearly, the market expects the new administration to look favorably on MA plans, a reasonable assumption given President Trump's industry-friendly history.

Open enrollment is overwhelming

Between October and January, during Medicare open enrollment, insurers and brokers blast seniors with commercials, phone calls, and direct mailers. One broker bombarded their database of 7 million seniors with 17 million phone calls.[37] CMS amended advertising rules limiting the sale of consumer data without express consent and expanded the scope of marketing materials that require prior approval for use with seniors.[38] At least one predatory company had to declare bankruptcy as a result.

MA looks appealing on the surface. It's convenient to enroll once and get full Part A, Part B, and Part D coverage. Carrier rebates keep premiums fairly low, especially as independent Part D premiums soar. They include plenty of extras, like gym memberships, dental coverage, and debit cards for over-the-counter supplies. They also have annual out-of-pocket maximum protections and don't require a companion Medigap policy. It's too bad that enrollees don't know that the price for the extra bells and whistles is excessive prior authorization requirements, egregious bot-driven claim denials, and a shrinking network of doctors and hospitals who accept Medicare Advantage.

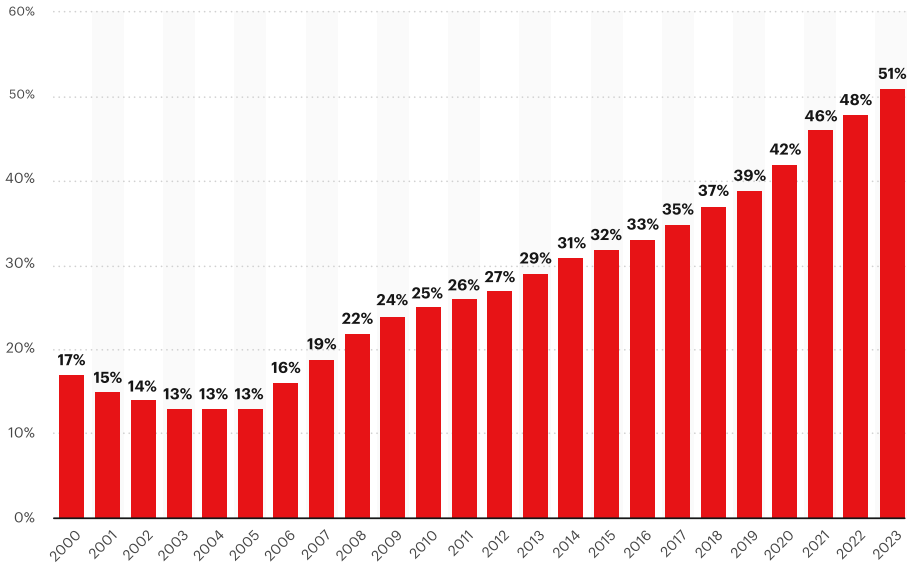
Providers take note, enrollment is shifting

The blitz appears to be working as MA enrollment has been steadily growing. It's risen from 13% in 2005 to over half of enrollees today.[39] By 2030, enrollment is predicted to be at 60% of the eligible population, which grows every day.[40] Health systems need to pay attention to this trend. MA plans are not traditional Medicare. Contrary to the claims that MA keep costs in check, research shows that the federal government pays MA plans 123% what they'd have paid if enrollees stayed in traditional Medicare.[40] Providers aren't reaping the benefits, and neither are patients or taxpayers. While health systems incur 100% of the costs, and Medicare generally covers around 80% of them, MA plans usually pay closer to 65% of cost when all administrative hurdles and denials are taken into account.

Not only are payments significantly lower, MA is plagued with the same issues that pervade the commercial insurance market, but at much higher levels. In October 2024, a Senate subcommittee issued a report[41] investigating the three top MA plans, administered by UnitedHealthcare, Humana, and CVS Health, for "intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities."[42] Findings showed all three denied stays for post-acute care at higher rates than other types of care, and at least three times the overall denial rate. The report showed Humana's denials of post-acute care were 16 times higher than their overall denial rate.[42] No matter how business friendly an administration may be, facts like this can't be overlooked.

Whatever the regulatory environment may be, many health systems have made the decision on their own to exit unfavorable MA contracts. In 2024, 32 health systems discontinued at least one MA arrangement, and five ended all of them.[43] More than 20 health systems have already discontinued MA contracts in 2025, and the number will surely continue to grow.[44]

Medicare Advantage penetration within total Medicare from 2000 to 2023



Source: Statista [39]

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MA enrollment will continue to grow, and many providers will have no choice but to walk away from unfavorable contracts.

Health insurers are a fact of life in the United States. People simply cannot afford to receive care without the coverage they provide. A business-friendly Congress may see MA plans as a way to shift expensive Medicare beneficiaries to private companies that supposedly do a better job managing care. Many people may see expansion of MA coverage as a step toward universal coverage and away from employer-sponsored health coverage. Unlike the commercial insurance market, the federal government has an advantage in concentrated oversight. They need to use it. We need more investigations like the ones into abusive prior authorizations and bot-generated denials. But more than that, we need those investigations to result in legislation with strict penalties for bad behavior. Health insurers have proven beyond a shadow of a doubt that they will not police themselves. Congress needs to do it.

Until then, health systems have the power to decide their own fate — they can walk away from abusive practices and contracts that don't pay enough to keep the lights on or they can choose the best two or three partners and limit their contracting to those payors. Are we seeing the beginnings of a movement in this space?

Contract language and terms

Can you afford low rates *and* bad contract terms?

As tensions between payors and providers rise, more contract disputes will go public

Historians have documented contracts in the ancient world all the way back to 2,300 BC.[45] As long as humans have been trading services, there's been a process to formalize the terms and conditions of an agreement. There were probably contract disputes in Mesopotamia, Egypt, and Rome — and lawyers or diplomats had to intervene to settle the dispute. Some health insurance executive probably made a profit on that work too.

Translation: Your claim has been denied.

Is it negotiating or bullying?

Negotiations are a natural part of the contracting process — and there are those who enjoy the give and take of a spirited and fair negotiation. When the power dynamic between parties is grossly imbalanced, though, it's not much of a negotiation. When 60% or more of commercially insured patients are under one health plan, that's the definition of imbalanced. How is it even legal?

In our experience, in Kansas, the local Blue plan board meets to decide what the increase will be, and the hospitals are just expected to accept it. In Iowa, the Blue plan has three tiers of reimbursement — and there are no negotiations. In other states, independent Blue plans have forced their own DRG methodology, their own EAPGs for outpatient care, or a cost-plus model. As a result, almost all independent hospitals have been driven to become part of a massive system.

Payors claim no responsibility for the health system consolidation they blame for the increased cost of care. At the same time, they continue to hand out premium increases — pre-pandemic and post-pandemic — at two to three times inflation. Where does all this money go? Definitely not to providers.

When the stakes are high, as they are in managed care contracts, it doesn't take much gas on the fire for a negotiation to evolve into a dispute. As Lovisa Gustafsson, Vice President of The Commonwealth Fund, told Greenville Business Magazine:

> "While these disputes crop up around the country, it's hard to know just how often because they aren't tracked and contracts between plans and providers are private...It seems like it's coming up more often, although there are no hard and fast statistics on this."[46]

While it's not possible to know how many negotiations between payors and providers take a turn for the worse every year, there is data about how many have been covered in the media:

- 2022: 51 disputes in 24 states[47]
- 2023: 86 disputes in 34 states[47]
- 2024: 133 disputes in 38 states[48]

In all three years, about 45% of disputes resulted in network disruption and delayed care when the parties failed to come to an agreement in a timely manner. Does anyone notice a trend?

Financial pressure on healthcare providers is intense

In the ten years before the pandemic, the average annual inflation rate in the U.S. was approximately 2%.[49] Every year since 2021 has seen an average inflation rate of 4% or higher, with a peak of 8% in 2022 for all services.[49]

However, expenses for healthcare have risen at a much faster pace. From 2014 to 2023, inflation rose almost 28% but hospital employee compensation costs rose 45%.[50] In 2021 and 2022, more than 145,000 healthcare providers left the field.[51] The American Hospital Association predicts a shortage of about 100,000 healthcare providers by 2028.[52] These staffing shortages have caused an increased reliance on expensive contract workers that resulted in a 258% increase in contract labor costs between 2019 and 2022.[53]

The American Hospital Association wrote:

> "Persistent workforce shortages, severe fractures in the supply chain for drugs and supplies, and high levels of inflation have collectively fueled hospitals' costs as they care for patients 24/7 ... Taken together, these issues have created an environment of financial uncertainty where many hospitals and health systems are operating with little to no margin."[54]

And why is it that hospitals and health systems are operating with little to no margin? The 2023 dispute between UnitedHealthcare and Prisma, a large health system serving 1.5 million patients in South Carolina, is a classic example.[46] Like many other health systems, Prisma had a difficult time coming out of the pandemic and had to "adjust to an extremely tight labor market, and the steeply rising costs for medical supplies and equipment." They reportedly "basically broke even posting a $500,000 loss from operations."[46]

They had no choice but to ask for higher payment rates in their managed care contracts and were able to come to agreements with every major insurer except UnitedHealthcare. In a statement, UnitedHealthcare described Prisma's request for a 10% increase over two years as "outlandish price hikes."[46] Speaking about the UnitedHealthcare-Prisma dispute in Greenville Business Magazine, Dr. Georges Benjamin, executive director of the American Public Health Association, said:

> "Frequently, it's negotiated to pay a fee below cost. And particularly when the insurer has a large percentage of patients in a catchment area, it can make the business unsustainable... You can't make this up on volume. A widget that costs you more to build than to sell, you can't sell your way out of that. It's the same with care if there is more to deliver than you receive in reimbursement... If you drive that hospital out of business, there is nobody to negotiate with next time. We need tighter regulations, particularly when there's a limited number of providers in the community, so patients don't get caught in the lurch."[46]

Can you think of any other industry in the United States that is expected to accept payments lower than the actual cost of goods or services?

All over the country health systems like Prisma are struggling or even posting record losses, shutting down service lines, or closing their doors altogether. Even health systems that appear to have strong performance might have service lines that are struggling. The system as a whole may be bolstered by strong non-operating income driven by a healthy stock market investment portfolio. In contrast, UnitedHealth Group posted $22.4 billion in profit in 2023, although that did shrink to a measly $14.4 billion in 2024.[55] In a press release, UnitedHealth Group CEO, Andrew Witty, was quoted as saying, "The people of UnitedHealth Group remain focused on making high-quality, affordable healthcare more available to more people while making the health system easier to navigate for patients and providers, positioning us well for growth in 2025."[55] Make no mistake, in this scenario, "affordable healthcare" means UnitedHealthcare expects the providers who deliver the care to continue to do it at a loss. How they can make a statement like that with a straight face is anybody's guess.

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Payors say its time for a change. Yet their behavior doesn't show it.

> "When someone shows you who they are, believe them."[46]
>
> — Maya Angelou

The public airing of a contract dispute isn't ideal for either side because the media doesn't cover all the complexities that led to an impasse. "It's the age-old conflict between insurers and providers," says one article.[56] Yes, because payors haven't changed how they treat their provider partners and providers shouldn't have to take it.

Payors speak to the potential for huge economic harm if they knuckle under to "outlandish demands." Andrew Witty sets UnitedHealthcare up as the champion of affordable healthcare, fighting for consumers against mustache-twirling, villainous providers. As if administrative burdens imposed by UnitedHealthcare aren't a significant source of the increased cost of delivering care. It boggles the mind. Elevance, Anthem, and each individual Blue plan take similar positions publicly. Consider the following though:

- BCBS of Michigan has most hospitals on a cost-plus contract. Yet, they are so bloated that they need to "find $600 million" over the course of the next year or they will need to lay-off staff.
- Most payors have had record profits and financial statements. FL Blue now hides financials that used to be easily searchable. Interesting behavior for a not-for-profit organization — a $30+ billion revenue organization no less.
- Humana has substantially grown its Medicare Advantage customer base. Yet in the last two years its networks have lost the largest number of health systems due to payment issues and administrative burdens.

Meanwhile, healthcare providers and health systems are fighting for their lives as well as their patients'. Providers need improved payments or they won't be able to provide care at all. For the last decade, many providers have signed new boilerplate agreements or accepted new language and new policies in exchange for better rates. Only in the last four years have providers changed their approach. It's growing more and more important for providers to read, and fight, insidious or vague contract language that might be open to interpretation. Want to pay for the privilege of appealing your denial?[57] It's a very real possibility. Providers cannot afford to accept additional administrative requirements and below inflation increases.

To term or not to term, that is the question

Our advice to providers is to start planning for contract renewals 10 to 12 months before the renewal date. Use transparency data and other analytics to understand your competitive position and build the case for your position heading into the renewal. Some common approaches to negotiations are:

- **Term every payor contract at the start of negotiations.**
  - **Positives:** sets clear deadlines, lessens planning variability, removes political debates about term decisions
  - **Negatives:** adds tension to negotiations that may have been routine, creates a perception that the organization is constantly in conflict
- **Term only if negotiations aren't progressing.**
  - **Positives:** adds urgency with impending deadlines, shows resolve, grabs attention since terms aren't always on the table
  - **Negatives:** shortens timeline for planning, can prolong negotiations, introduces the possibility for political intervention in the decision to term
- **Allow every contract to expire.**
  - **Positives:** eliminates the need for either side to term, removes political interference in term decisions, creates consistency for planning
  - **Negatives:** results in all contract provisions expiring — even the good ones, adds pressure if expiration timing isn't ideal

Whatever approach your organization takes when initiating renewal discussions, don't wait to start discussing your communication strategy. If your negotiations become contentious, a clear and defensible rationale is key to gaining public support. Start developing your communication strategy about 8 to 9 months prior to the renewal date — don't wait until it looks like negotiations might break down.

Conclusion

So, now what?

Maybe it made sense to leave insurance regulation in the hands of the states when health insurance was delivered by hundreds of small, regional carriers. Over time, commercial membership, including administration of self-insured plans, has consolidated under just a few huge national corporations. And they're not just insurers anymore, not by a long shot. Add the complexities of ERISA into this mix, and you have dangerous cocktail.

CVS Health owns Aetna, the PBM CVS Caremark, MinuteClinic, Oak Street Health, Signify Health, and retail pharmacy locations throughout the country. They've said that they want to change how healthcare is delivered in this country, and they're not alone. UnitedHealth Group and Cigna have also completed acquisitions of pharmacy benefit managers, surgery centers, specialty pharmacy suppliers, ancillary providers such as home health, hospice, and physician practices. Consolidation of this magnitude warrants federal oversight especially given the impacts of the Change Healthcare hacking incident.

Historically, it's been very difficult to achieve any meaningful change related to health insurance coverage at the federal level. It took eight years to pass traditional Medicare and took five to pass and implement the Affordable Care Act. Almost 15 years ago, Senator Dianne Feinstein said:

> "Without further legislative action, I am concerned that health insurance companies will continue to do what they have done for far too long: put their profits ahead of people. Premium increases are forcing Americans to choose between keeping health care coverage and making their mortgage payments, all while big national insurance companies enjoy increasing profits."[58]

It's disheartening that she could have made that same comment today. In a December 2024 Congressional hearing on anti-trust issues, Senator Josh Hawley said:

> "If the insurance company can own the PBM, can own the pharmacies, can own the doctors' offices, in some cases can now own the hospitals, the only person who seems to benefit from that arrangement is the insurer, the vertical integrator. The people who seem to lose out are the patients who no longer have any meaningful choice anywhere... This has got to stop. It's highly detrimental to patients, to cost, and to the quality of care."[59]

In December 2024, Senators Elizabeth Warren joined Senator Hawley[60] to introduce the bi-partisan Patients Before Monopolies (PBM) Act while Representatives Diana Harshbarger and Jake Auchincloss [61] introduced a sister bill to the House of Representatives. Should the act pass, insurance companies and PBMs would need to divest themselves of any pharmacies they own.

Time will tell whether the PBM Act gets any traction in a more business-friendly Congressional environment. Yet there are even more areas that could use attention. For a start, we suggest:

- Limits on narrow networks that steer utilization to insurer-owned providers
- Requirements for removal of dysfunctional administrative practices, including denials, with penalties for non-compliance
- Equitable treatment for providers and payors when it comes to consolidated market share

Join us as we watch how 2025 unfolds.

We'll be posting about emerging issues and trends on go.unlockhealthnow.com/managedcare and you can follow us on LinkedIn.

References

[1] Committee for a Responsible Federal Budget. Medicare Framework Calls for Important Site-Neutral Reforms. November 1, 2024. Accessed January 27, 2025.

[2] Boccia R. CBO Update: Medicare and Social Security are Key Drivers of Exploding Debt. Cato Institute. June 25, 2024. Accessed January 27, 2025.

[3] Ambulatory Surgery Center Association. Reducing Medicare Costs by Migrating Volume from Hospital Outpatient Departments to Ambulatory Surgery Centers. October 2020. Accessed January 27, 2025.

[4] Nerdwallet. Cost of living calculator. Accessed January 27, 2025.

[5] Emerson J. 20 Things to know about site-neutral payment policies. Becker's Hospital Review. November 8, 2024. Accessed January 27, 2025.

[6] Brot-Goldberg Z, Cooper Z, et al. Is There Too Little Antitrust Enforcement in the US Hospital Sector? Yale Tobin Center for Economic Policy. April 2024. Accessed January 27, 2025.

[7] Unlock Health. Debunking the RAND Study: How Flawed Data is Hurting U.S. Hospitals. September 12, 2024. Accessed January 27, 2025.

[8] Chatterjee P. Causes & Consequences of Rural Hospital Closures. Journal of Hospital Medicine. October 3, 2022. Accessed January 27, 2025.

[9] Levins H. Exploring the Policies That Are Closing Rural Hospitals. University of Pennsylvania Leonard Davis Institute of Health Economics. April 25, 2024. Accessed January 27, 2025.

[10] Olsen E. More than 700 rural hospitals at risk of closing: report. HealthCare Dive. August 7, 2024. Accessed January 27, 2025.

[11] Haupert J. Chair File: Recognizing the "Power of Rural" in Advancing Health. American Hospital Association. November 13, 2023. Accessed January 27, 2025.

[12] May S, Noether M, Stearns B. Hospital Merger Benefits: An Econometric Analysis Revisited Executive Summary. American Hospital Association. Accessed January 27, 2025.

[13] Wise J. GOP FTC Commissioner Says She'd Consider Undoing Merger Guidance. Bloomberg Law. October 30, 2024. Accessed January 27, 2025.

[14] Ray J. Americans Express Real Concerns About Artificial Intelligence. Gallup. August 27, 2024. Accessed January 27, 2025.

[15] American Medical Association. AMA issues new principles for AI development, deployment & use. November 28, 2023. Accessed January 27, 2025.

[16] Rucker P. Miller M. Armstrong D. How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them. ProPublica. March 25, 2023. Accessed January 27, 2025.

[17] Rucker P. Miller M. Armstrong D. Congressional Committee, Regulators Question Cigna System That Lets Its Doctors Deny Claims Without Reading Patient Files. May 16, 2023. ProPublica. Accessed January 27, 2025.

[18] The Estate of Gene B. Lokken and The Estate of Dale Henry Tetzloff, individually and on behalf of all others similarly situated vs. UnitedHealth Group, Inc., UnitedHealthcare, Inc., NaviHealth, Inc., and DOES 1-50, inclusive. United States District Court District of Minnesota. Accessed January 27, 2025.

[19] Napolitano E. UnitedHealth uses faulty AI to deny elderly patients medically necessary coverage, lawsuit claims. CBS News. Accessed January 27, 2025.

[20] American Cancer Society. People Ages 45-49 Are Not Getting Screened for Colorectal Cancer. Accessed January 27, 2025.

[21] California State Senator Josh Becker via Senate.CA.gov. New California Law Prohibits Using AI As Basis To Deny Health Insurance Claims. January 6, 2025. Accessed January 27, 2025.

[22] Office of the New York State Attorney General Letitia James. Inaccurate and inadequate: Health plans' mental health provider directories. December 27, 2023. Accessed January 27, 2025.

[23] Blau M. State regulators know health insurance directories are full of wrong information. They're doing little to fix it. Medical Marketing and Media. November 15, 2024. Accessed January 27, 2025.

[24] Pifer R. CMS has received 12K complaints of No Surprises noncompliance; won $1.7M in restitution. Healthcare Dive. August 22, 2024. Accessed January 27, 2025.

References

[25] Lagasse J. UnitedHealth AI algorithm allegedly led to Medicare Advantage denials, lawsuit claims. Healthcare Finance. November 15, 2023. Accessed January 27, 2025.

[26] American Hospital Association. Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Impacting Patient Care. September 2024. Accessed January 27, 2025.

[27] American Medical Association. Exhausted by prior auth, many patients abandon care: AMA survey. July 18, 2024. Accessed January 27, 2025.

[28] Biniek JF, Sroczynski N, Neuman T. Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022. Kaiser Family Foundation. August 8, 2024. Accessed January 27, 2025.

[29] American Psychological Association and American Psychiatric Association. Letter to Dr. Amar A. Desai, CEO, Optum Health. October 8, 2024. Accessed January 27, 2025.

[30] American Psychological Association. Optum pauses prepayment reviews that angered psychologists. October 25, 2024. Accessed January 27, 2025.

[31] Alder S. Nebraska Sues Change Healthcare Over February Ransomware Attack. The HIPAA Journal. December 17, 2024. Accessed January 27, 2025.

[32] Pollitz K, Pestaina K, Montero A, et al. KFF Survey of Consumer Experiences with Health Insurance. Kaiser Family Foundation. June 15, 2023. Accessed January 27, 2025.

[33] American Hospital Association. Payer Denial Tactics — How to Confront a $20 Billion Problem. Accessed January 27, 2025.

[34] Pollitz K, Pestaina K, Lopes L, et al. Consumer Survey Highlights Problems with Denied Health Insurance Claims. Kaiser Family Foundation. September 29, 2023. Accessed January 27, 2025.

[35] Joszt L. Humana Leaving Commercial Business, Will Focus on Government-Funded Programs. American Journal of Managed Care. February 23, 2023. Accessed January 27, 2025.

[36] Rowan K. Medicare Advantage Stock Prices After Trump Elected. The Rowan Report. November 15, 2024. Accessed January 27, 2025.

[37] Rowan T. Poor Joe is Out of A Job. The Rowan Report. June 27, 2024. Accessed January 27, 2025.

[38] Carter J. Final Rule Limits Broker Compensation, Requires Important Plan Improvements. MedicareRights.org. April 11, 2024. Accessed January 27, 2025.

[39] Statista. Medicare Advantage penetration within total Medicare from 2000 to 2023. Accessed January 27, 2025.

[40] Neuman T, Freed M, Biniek JF. 10 Reasons Why Medicare Advantage Enrollment is Growing and Why It Matters. Kaiser Family Foundation. January 30, 2024. Accessed January 27, 2025.

[41] U.S. Senate Permanent Subcommittee on Investigations. Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care. October 17, 2024. Accessed January 27, 2025.

[42] American Hospital Association. Senate report scrutinizes Medicare Advantage prior authorization denials for post-acute care. October 17, 2024. Accessed January 27, 2025.

[43] Emerson J. 32 health systems dropping Medicare Advantage plans | 2024. Becker's Hospital Review. December 26, 2024. Accessed January 27, 2025.

[44] Emerson J. 21 health systems dropping Medicare Advantage plans | 2025. Becker's Hospital Review. January 9, 2025. Accessed January 27, 2025.

[45] Cunanan J. From Barter to Written Agreements: A Look into the History of Contracts. Lexagle. July 22, 2024. Accessed January 29, 2025.

[46] Osby L. Disputes Between Health Systems and Insurers Bring Challenges to Patients. Greenville Business Magazine. February 12, 2024. Accessed January 29, 2025.

[47] Miller CS, Gutierrez P, Chauhan A. End of Year Update: Payer-Provider Disputes in the Public Eye in 2023. FTI Consulting. January 16, 2024. Accessed January 29, 2025.

[48] Miller CS, Pitt RA, Chauhan A. End of Year Update: Provider-Payer Dispute Data Update. FTI Consulting. January 21, 2025. Accessed January 29, 2025.

References

[49] Srinivasan H. Historical U.S. Inflation Rate by Year: 1929 to 2024. Investopedia. November 4, 2024. Accessed January 29, 2025.

[50] American Hospital Association. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities. May 2024. Accessed January 29, 2025.

[51] Vogel S. Healthcare worker exodus continued through 2022, new data shows. Healthcare Dive. October 17, 2023. Accessed January 29, 2025.

[52] American Hospital Association. 5 Health Care Workforce Shortage Takeaways for 2028. Accessed January 29, 2025.

[53] Staffency. Healthcare Workforce Data & Statistics You Need to Know. September 26, 2024. Accessed January 29, 2025.

[54] American Hospital Association. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities. May 2024. Accessed January 29, 2025.

[55] Minemyer P. Optum Rx commits to passing through 100% of drug rebates, Witty says. Fierce Healthcare. January 16, 2025. Accessed January 29, 2025.

[56] Pinder J. Patients suffer as insurers and hospitals fight over contracts. ClearHealthCosts.com. January 4, 2025. Accessed January 29, 2025.

[57] Tepper N. Insurers inventing more roadblocks to claims, providers say. Modern Healthcare. January 22, 2025. Accessed January 29, 2025.

[58] Senator Dianne Feinstein Testimony on Health Insurance Rate Authority Act of 2010. April 20, 2010. Accessed January 27, 2025.

[59] Senator Josh Hawley official YouTube account. December 2024. Accessed January 27, 2025.

[60] Warren.Senate.gov. Patients Before Monopolies Act. December 2024. Accessed January 27, 2025.

[61] Harshbarger.House.gov. Rep. Harshbarger Introduces Legislation to Eliminate the PBM Monopoly on the Pharmaceutical Delivery Chain. December 11, 2024. Accessed January 27, 2025.