



Skimming: How Complexity Raises Healthcare Costs—And What Government Can Do About It

JUNE 18, 2026 — JEANNE LAMBREW AND JOSHUA VARCIE

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As Americans’ [concerns about healthcare affordability climb](#),¹ the U.S. Congress, on a bipartisan basis, is [blaming health insurance companies seeking profits](#).² This concern is valid, especially regarding insurers that have [bought the healthcare providers](#) that they are supposedly negotiating with for lower prices.³ Consolidation such as this typically leads to higher prices in healthcare, as this report explains. However, this picture is incomplete: the vast complexity of the multilayered U.S. healthcare system helps enable these consolidated entities to skim profits by exploiting loopholes at numerous points, from when a person first seeks care to when their insurer bills for it. Sometimes these loopholes are created by well-intentioned policies, but they have unintended consequences and often have become profit opportunities for interrelated and consolidated corporations. The end result is higher prices for most forms of care. This affects the [federal government](#),⁴ [state governments](#),⁵ businesses’ ability to [support wage increases](#),⁶ and [American families](#).⁷

This report provides examples of how the complexity of the U.S. healthcare system contributes to consolidated healthcare corporations exploiting loopholes and skimming profits, driving up costs. It also describes broad policy approaches to address this problem that would lower health insurance premiums, cost sharing, and administrative barriers to coverage for patients and providers alike.

Background: How Complexity Creates Profit-Skimming Opportunities

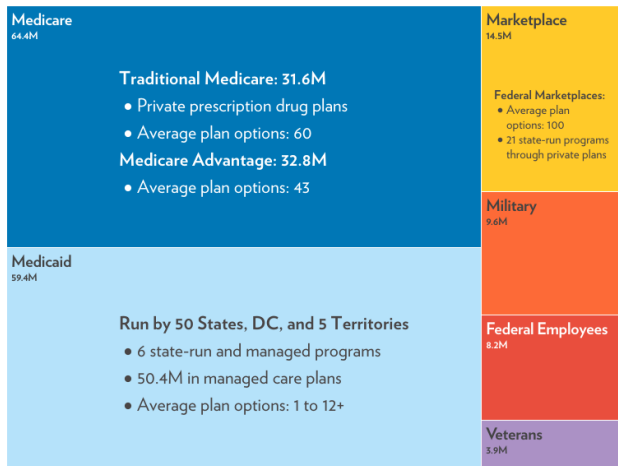
The U.S. healthcare system is complex: more so than that of other nations.⁸ It has multiple types of public coverage (for example, Medicare, Medicaid, Veterans’ Health Administration), private coverage (for example, self-insured plans, fully insured plans, plans subject to different types of regulations), and programs for the uninsured (for example, public hospitals, community health centers). Most programs have their own benefits, providers, and processes for accessing services. Insurers and providers also [hire a wide array of intermediaries](#) to maximize revenue.⁹ Just looking at the major public coverage programs, Medicaid consists of fifty-six different state and territorial programs; the health insurance marketplace is one federal and twenty-one state programs; and within these programs, individuals choose from among a number of plans ranging from an average of forty-three private Medicare Advantage plans to 100 plans for the average person in the federally run marketplace. (See Figure 1.)

This report can be found online at: tcf.org/content/report/skimming-how-complexity-raises-healthcare-costs-and-what-government-can-do-about-it/

FIGURE 1

EVEN PUBLIC COVERAGE PROGRAMS ARE COMPLICATED

Number of government programs and plans



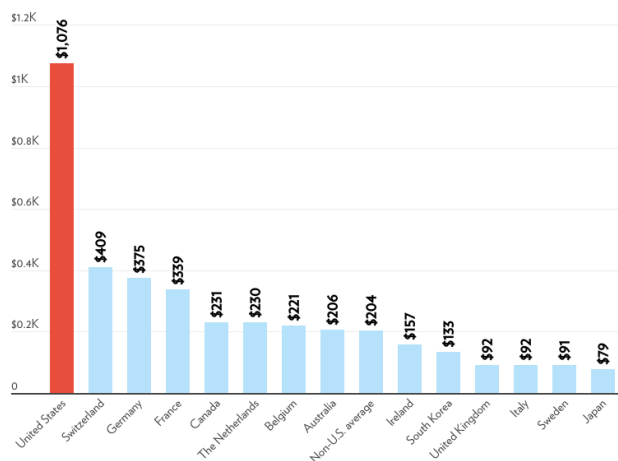
THE CENTURY FOUNDATION Source: Authors' calculations based on U.S. Census Bureau health insurance coverage for 2024; Office of Personnel Management; Centers for Medicare and Medicaid Services; KFF. Notes: Individuals may have multiple sources of coverage. Coverage from U.S. Census except for FEHB which is from program data.

Not all complexity and administrative costs are wasteful and [some management is necessary](#) to maintain patient choices and target inefficient and ineffective healthcare costs.¹⁰ However, research suggests that half of all administrative costs are wasteful.¹¹ The United States spends over \$1,000 per person per year on healthcare administrative costs—five times more than the average of other wealthy nations—contributing to what adds up to be the [most expensive healthcare system in the world](#) (see Figure 2).¹²

FIGURE 2

U.S. HEALTH SYSTEM ADMINISTRATIVE COSTS ARE HIGH

Healthcare administrative costs per capita, 2023



THE CENTURY FOUNDATION Note: Local currencies are converted to U.S. dollars using purchasing power parity. Source: "How Does the U.S. Healthcare System Compare to Other Countries?" Peter G. Peterson Foundation, October 7, 2025, <https://www.pgpf.org/article/how-does-the-us-healthcare-system-compare-to-other-countries/>

The U.S. healthcare system’s complexity makes oversight difficult and enables loopholes that can be exploited for profits. Some of these loopholes result from well-intended policies; others are workarounds used by otherwise fiscally responsible organizations to generate extra revenue. They occur in both public and private health coverage programs and are used by both nonprofit and for-profit organizations. Such loopholes produce revenue over and above the layers of administrative costs that occur from one end of the system to the other.

This report describes complexity-induced loopholes in three key transaction points in the health system: when a patient is referred for care, when a pharmacy fills a prescription, and when an insurer bills the person, employer, or government for coverage. It also describes how such loopholes can be more effectively exploited when a web of ownership connections and private equity acquisition allow for mutual profits. It concludes with ideas on approaches to close the loopholes described in the report, limit financial relationships that widen such loopholes, and simplify the system through government intervention to limit excessive profits and prevent loopholes from opening in the first place.

Points in the Health System Where Costs Escalate

The journey a person travels through the health system can take many turns, depending on that person’s health needs, preferences, local providers, and health insurance coverage. The journey that the bills for such care take through a number of “middlemen” is [equally complicated](#), as illustrated in Figure 3, reproduced from a recent Georgetown Center for Health Insurance Research study.¹³

Research consistently finds that self-referring physicians order more services than non-self-referring physicians, which drives up healthcare costs. For example, a 2011 study estimates that self-referring physicians order imaging services about two to two-and-a-half times more often than those who do not self-refer.¹⁸ Similarly, a [2012 GAO report](#) found that, in 2010, self-referring physicians “made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring, ...cost[ing] Medicare about \$109 million.”¹⁹ (See Figure 4.) Together, this evidence suggests that some physicians are taking advantage of the in-office ancillary services exception in a way that increases healthcare costs with no clear quality or benefit to patients.

Filling A Prescription: Pharmacy and Prescription Drug Acquisition

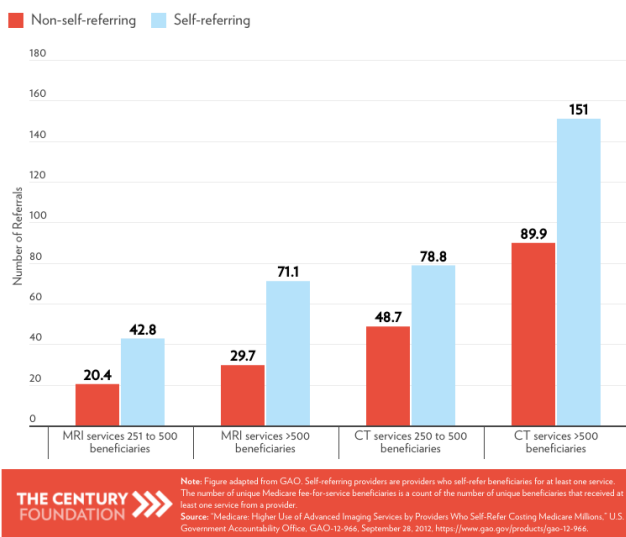
By the time a patient goes to pick up their prescriptions at a pharmacy, a large and complex process has already played out behind the scenes that affects the cost of that prescription, who pays, and who profits. In the United States, drug access and pricing systems rely on a variety of actors: manufacturers, wholesalers and distributors, payers, pharmacies, pharmacy benefit managers, and the government. The supply chain is relatively simple: the manufacturer sends the drug to a wholesaler, which then stocks pharmacies, which then provide drugs to patients. That simplicity stands in stark contrast to the byzantine pricing system for prescription drugs that are paid for through health coverage plans.

Like many medical services and products, the price a private or Medicare Part D insurer actually pays for a drug is determined through negotiation between the insurer and the drug manufacturer within a complicated set of policies governing drug patents, exclusive marketing rights, and approvals for safety and efficacy. Most insurers rely on third-party administrators, known as pharmacy benefit managers (PBMs), to negotiate with manufacturers on their behalf, set formularies that determine how much a plan enrollee will pay for a specific drug out-of-pocket, and manage drug acquisition and distribution for plan enrollees. Drug payment policy differs from other medical services because it typically follows a rebate-based model: insurers purchase the drug at the list price and negotiated discounts, called rebates, are applied afterwards based on use. A drug company may offer a greater discount to an insurer or PBM that makes its drug preferred (with low cost sharing) on its formulary since enrollees will be more likely to pick that drug over a competitor, with the increased volume offsetting the deeper discount to the drug companies. This rebate model disadvantages drugs that have low prices and thus limited rebates as well as generic drugs.

FIGURE 4

PHYSICIANS ORDER MORE TESTS WHEN REFERRING TO THEIR OWN FACILITIES

Comparison of average number of services referred by non-self-referring and self-referring providers, 2010



These layers of complexity create opportunities for skimming at multiple points in the drug supply chain and payment processes, especially for brand-name drugs. For example:

- Manufacturers set a drug’s initial price to maximize profit, taking into account the availability of brand-name competitors, generic alternatives, patent policies (as described below), and the price schedules and rebates in government programs.
- Wholesalers and distributors generate profit by charging manufacturers for distribution services and by selling drugs to pharmacies at a markup over the manufacturer’s initial price.
- Pharmacies generate profit by dispensing drugs at prices above acquisition cost and by charging dispensing fees when selling a drug to a patient. These include traditional, brick-and-mortar stores such as community pharmacies and chains such as CVS and Walgreens as well as mail-order services such as ExpressScripts and Amazon Pharmacy, which make up a [growing share](#) of the market.²⁰
- PBMs generate profit by charging fees to pharmacies for network inclusion, to drug manufacturers for administration and preferred formulary placement, and to payers for negotiating and managing benefits on their behalf. As a result of consolidation, many PBMs now [own their own](#) mail-order or specialty pharmacies.²¹

CASE STUDY: PATENT GAMING

To encourage prescription drug innovation, the U.S. government awards patents to drug manufacturers that [cover various features of a drug](#), such as its chemical composition, the conditions it treats, or its manufacturing processes.²² Patents reward innovation by preventing other manufacturers from copying an innovator’s products and processes for a period of time.

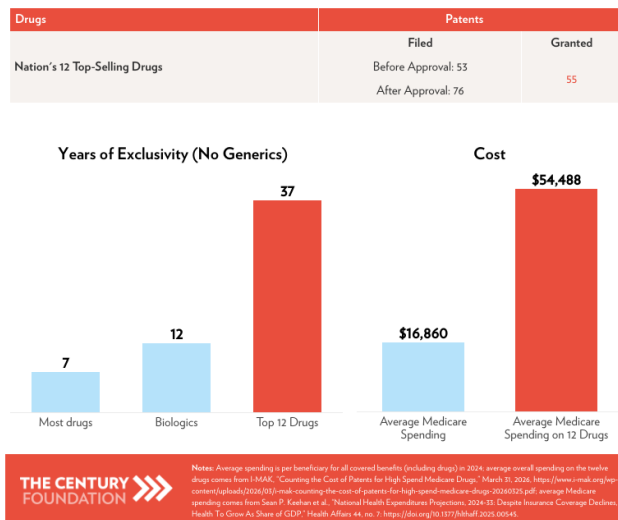
However, manufacturers have exploited the patent system to drive up profits through a process known as patent gaming. Patent gaming refers to strategies undertaken by drug manufacturers to extend patent protection beyond the

expiration of a drug’s original patent, allowing manufacturers to [maintain market exclusivity](#) and continue charging high prices.²³ The nation’s twelve top-selling drugs, for example, secured fifty-five patents for thirty-seven years of exclusivity (see Figure 5). Manufacturers use a variety of complicated tactics such as [patent thickets](#), [evergreening](#), [product hopping](#), and [reverse payment settlements](#).²⁴ For example, AbbVie protected [\\$114 billion in revenue](#) from competition for its blockbuster drug Humira by applying for 311 patents, shifting patients to newer patent-protected formulations, and suing rivals to delay the entry of similar drugs.²⁵ Recent research concludes that patent gaming delays competition in the prescription drug market, allowing manufacturers to maintain higher prices for longer periods.²⁶ One recent study estimates that [such delays resulted in](#) \$1.9 billion in excess spending for commercial plans and \$1.6 billion in excess spending for Medicare over a two-year period.²⁷

FIGURE 5

EXCESSIVE USE OF PATENTS DRIVE UP COSTS OF PRESCRIPTIONS

Number of patents, years of exclusivity, and average costs of the nation’s twelve top-selling drugs, July 2025



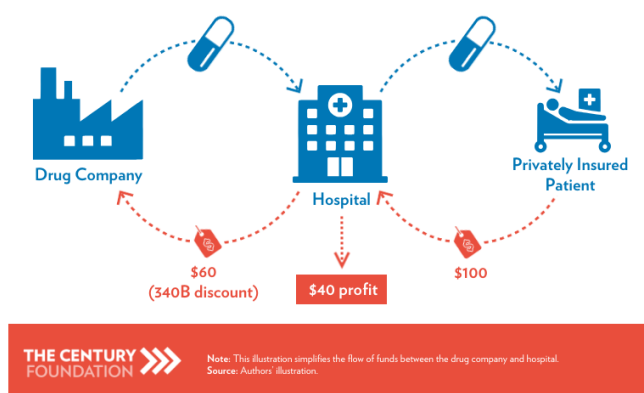
CASE STUDY: THE 340B DRUG DISCOUNT PROGRAM

Another example of skimming in the prescription drug space is the 340B Drug Discount Program. The 340B program aims to make prescription and physician-administered drugs (like chemotherapies and other infusions) more affordable for facilities serving low-income people by setting an upper limit on the price that a drug manufacturer can charge a participating entity. Participating entities, such as nonprofit hospitals and community health centers, qualify for the program by serving a large share of low-income or uninsured patients. While certain policies direct community health centers to pass along discounts to patients, there is no such policy for entities such as hospitals.

Entities that do not pass along 340B discounts to patients can profit when providing medications to privately insured patients. This is because reimbursement rates are determined by the drug's full negotiated rate when the drug is sold, not the discounted rate, and the rebate goes to the entity rather than the insurance company. For example, suppose the 340B program requires a manufacturer to provide a 40 percent discount on a \$100 drug to a 340B hospital. The hospital pharmacy charges the patient's insurer \$100. Since the hospital only pays \$60 to acquire the drug, it generates \$40 in profit (see Figure 6).

FIGURE 6

HOW PROVIDERS CAN PROFIT FROM PUBLIC DRUG PRICING PROGRAM



Some hospitals appear to be taking advantage of opportunities for skimming created by the 340B program. Several studies have found little relationship between hospitals' 340B participation and the level of provision of services to vulnerable populations, suggesting that hospitals are not using 340B revenues as the program intended.²⁸ Furthermore, one study shows that clinics affiliated with 340B hospitals are more likely to be [located in affluent areas](#) with higher insurance rates, which allows the clinic to generate higher profits from the program.²⁹ Finally, several studies suggest that 340B providers prescribe more drugs or more expensive drugs than non-340B providers, perhaps to increase the profits the provider can generate from the program.³⁰ While these findings provide strong evidence of skimming by participating 340B hospitals, the extent to which skimming occurs is largely unknown because 340B providers are not required to report how they use their 340B revenue.

Paying the Bills: Insurer Administration

In the United States, over [90 percent of people have health insurance](#) to help pay for their medical costs.³¹ Over 50 percent of insured Americans obtain [private insurance through an employer](#), with many employers paying a portion of the plan's costs for employees as part of an employee's benefit package.³² Others receive coverage from government programs (such as Medicare and Medicaid/CHIP) or in the individual market. The original and often-assumed purpose of insurers is to use the leverage of a group of enrollees to negotiate lower prices on their behalf, pay claims, coordinate services, and simplify access to care.

Yet, navigating health insurance plans is a complex process for patients. When deciding among health plans, people must compare premiums, deductibles, copayments, and covered services. When insurers only cover a portion of a service—or exclude it entirely—patients are significantly less likely to receive care.³³ People also want to know before signing up whether their providers and prescriptions are covered. Once enrolled, they expect that they can access covered benefits, providers, and services with minimum paperwork or processes. Government policy aims to help people make health plan choices through standardized

information and shopping platforms, marketing rules, and risk adjustment that increases payments for plans with a disproportionate number of high-risk enrollees. However, sometimes (perhaps often), patients select insurance plans that are [not in their best interest](#).³⁴

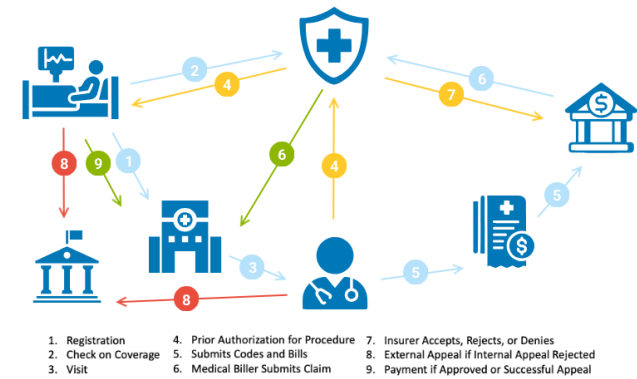
The patient experience reflects the complexity that underlies insurer billing and administrative structures in the United States. In private insurance plans and certain government programs, insurers negotiate with providers to determine reimbursement levels for services. If insurers and providers cannot agree on terms, the provider is excluded from the insurer’s network. As a result, patients in that plan typically pay much higher out-of-pocket costs when visiting the excluded provider which, in turn, discourages patients from seeking services from that provider. This structure contributes to a situation in which providers can be reimbursed at vastly different rates for the same service, depending on factors such as insurer and provider market power and the site at which care is delivered.

Once insurers and providers agree on a reimbursement framework, payment occurs through the billing process. In general, providers start by collecting insurance information and documenting the services delivered to patients, which are translated into standardized medical codes and submitted to an insurer as a claim. The insurer then adjudicates the claim and pays its share, and the provider bills the patient for the difference. If a patient’s claim is denied, the patient may appeal. Many of these steps are supported (or blocked) by for-profit, third-party firms that specialize in eligibility verification, medical coding, and claims processing. (See Figure 7.) Estimates suggest that [insurance-related billing and administrative costs](#) eat up 14.5 percent of professional revenue for primary care visits, 8 percent for general medicine inpatient stays, and 25 percent for emergency department visits.³⁵

FIGURE 7

COSTS ADD UP IN THE INSURER-BILLING PROCESS

Illustration of the steps from provider billing to private insurance company payment



THE CENTURY FOUNDATION Source: Author's illustration.

Insurers have multiple opportunities to engage in skimming when designing and negotiating insurance plans and reimbursement rates. For example, insurers can prioritize profits over affordability and access by narrowing their provider networks or using the copay or coinsurance to steer enrollees toward low-cost network providers, regardless of quality or convenience.

Insurers also profit when their enrollees’ health claims are less than the projected premiums. While this may occur when enrollees get early, effective preventive care, it can also result from “risk selection.” This occurs when insurer marketing and plan design discourage enrollment of people with chronic, costly pre-existing conditions. For example, an insurance plan network could have few specialists. The plan could have a high deductible with a low premium that attracts people with low risk, although it exposes such enrollees to substantially higher out-of-pocket costs if expensive or extensive care is needed.

Insurers can also profit by limiting access to covered benefits through prior authorization, frequent claims denials, and complicated appeals processes. While their purported intent is to discourage unneeded or unnecessarily expensive care, these tools often discourage enrollees from seeking needed care—or seeking insurer reimbursement for care—because of the administrative hurdles they impose, which lowers costs for insurers.

CASE STUDY: UPCODING IN MEDICARE ADVANTAGE

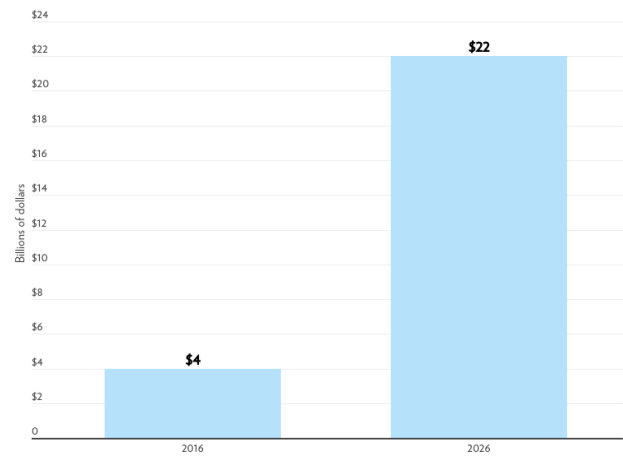
When enrolling in Medicare, beneficiaries can choose between two options: traditional Medicare or Medicare Advantage. In traditional Medicare, the federal government reimburses providers directly for services according to a fee schedule. In Medicare Advantage (MA), the federal government instead pays private insurance companies a fixed amount per enrollee (known as a capitation amount) to administer services. Several factors determine how much a plan receives, one of which is risk adjustment. Under risk adjustment, payments to plans for each beneficiary are based in part on a beneficiary’s documented medical conditions, with higher payments for enrollees expected to require more costly care. The system as currently designed incentivizes MA plans to enhance diagnosis reporting by systematically identifying and recording additional comorbidities. This often is done by reviewing a patient’s medical charts or performing a health risk assessment—sometimes in a patient’s home—to [ensure all possible diagnoses](#) are captured before data are submitted for reimbursement.³⁶ These coding enhancements, called upcoding, make beneficiaries appear sicker on paper, increasing plan reimbursement even when the additional comorbidities do not meaningfully change the cost of care.

Evidence shows that upcoding is associated with higher risk scores and increased payments in MA, which contribute to higher federal spending. For example, the Medicare Payment Advisory Commission (MedPAC) estimates that Medicare will spend \$76 billion more—or 12 percent of total Medicare Advantage payments—on Medicare Advantage enrollees in 2026 relative to if those instead enrolled in Medicare fee-for-service, with [about \\$22 billion](#) of the increase in payments being driven by upcoding.³⁷ (See Figure 8.) The budgetary implications are substantial: a recent estimate projects that upcoding will increase federal government spending by [\\$470 billion](#)³⁸ over the next ten years. Although the Centers for Medicare and Medicaid Services (CMS) adopted changes to its risk adjustment model in 2024, upcoding is still expected to [remain significant](#) in 2026, and further improvements to the model have been delayed.³⁹

FIGURE 8

HEALTH PLANS HAVE INCREASED MEDICARE PAYMENTS THROUGH UPCODING

Estimated coding intensity payments in excess of what fee-for-service spending would have been



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Source: “The Medicare Advantage Program: Status Report,” in Medicare Payment Policy: Report to the Congress (Washington, D.C.: Medicare Payment Advisory Commission, 2024), https://www.medpac.gov/wp-content/uploads/2024/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf

How Complexity Drives—And Is Reinforced by—Supply-Side Consolidation and Private Equity

As previously described, opportunities for hidden profits are a byproduct of the complex health system—a problem that is sometimes exacerbated when policy makers address concerns narrowly. This challenge in managing complexity is likely inherent in most multi-faceted systems. What has changed in recent decades in the healthcare system is the rise of consolidation, corporate acquisition of nonprofit providers, and complicated financial relationships among suppliers and “middlemen” or administrative intermediaries. In addition to exerting monopoly power, such arrangements can capture and maximize loopholes across the system. For example, a hospital can incentivize the physician practices it owns to refer to the laboratories, imaging facilities, and 340b pharmacies that it also owns. Such revenue, along with the relationships that enable it, may be easier to secure than revenue from negotiating lower input prices or improving enrollees’ health, for example. Moreover, consolidation, private equity, and other financial relationships are difficult to understand and publicly track, limiting effective oversight, accountability, and negotiation by payers, including federal and state governments.

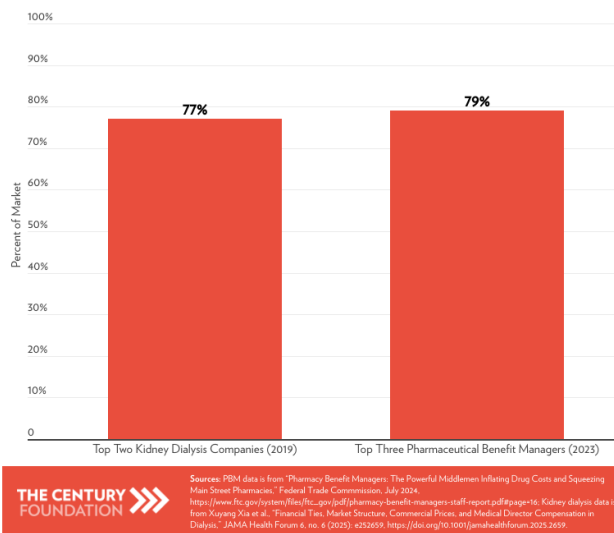
Mergers and Acquisitions within the Health System

In recent decades, consolidation of healthcare supply has occurred across the system. Some of this is horizontal integration across similar organizations (for example, hospitals merging with other hospitals). Since 1998, over 2,000 hospitals have merged. The share of hospitals belonging to a multi-provider system grew from 53 percent in 2005 to [68 percent in 2022](#).⁴⁰ A similar trend occurred at dialysis facilities, where the market share of two dominant chains (DaVita and Fresenius) grew from 59 percent in 2005 to [77 percent in 2019](#).⁴¹ PBMs, the “middlemen” in the prescription drug system, have also undergone consolidation.

FIGURE 9

CONSOLIDATION IN PARTS OF THE HEALTH SYSTEM IS HIGH

Examples of percent of the market share by a few dominant, for-profit companies



(See Figure 9.)

Horizontal integration has occurred among insurers as well as health providers, with large-scale acquisitions occurring rapidly in the late 1990s and early 2000s and continuing through the mid-2010s.⁴² These acquisitions increased the market share of the top four insurers in the fully insured commercial market from 61 percent in 2001 to [76 percent in 2013](#).⁴³ Although further horizontal integration has slowed in part because of the U.S. Department of Justice’s blocking of two large-scale proposed mergers in 2017 (Aetna and Humana, Anthem and Cigna), such integration has left enrollees with [few choices for insurance](#).⁴⁴ As of

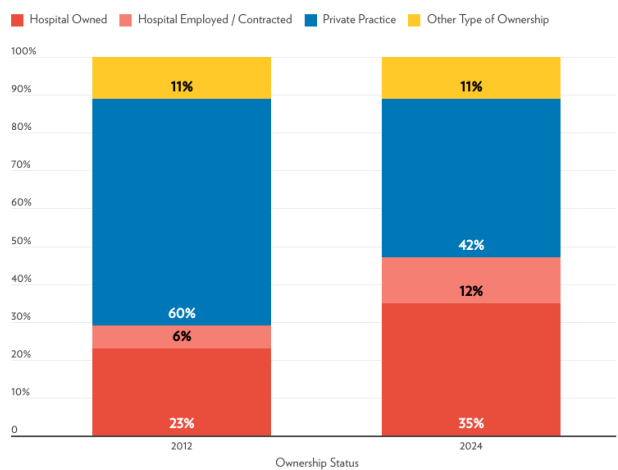
2023, [97 percent](#) of health insurance markets were highly concentrated.⁴⁵

The growth in horizontally integrated organizations has been accompanied by vertical integration of varied healthcare providers. Vertical integration brings physicians, hospitals, and other ancillary services under a single organizational umbrella. The share of physician practices owned, employed by, or under contract with a hospital or health system grew from 29 percent in 2012 to [47 percent in 2024](#) (see Figure 10).⁴⁶ Similarly, [in 2023, 77 percent](#) of commercial and Medicare Part D enrollees were enrolled in a prescription drug plan in which the PBM and insurer are vertically integrated, compared to 72 percent in 2022.⁴⁷ Proponents argue vertical integration promotes care coordination and alignment of incentives since, for example, the system benefits from lower spending when high-quality primary care prevents hospitalization. However, consolidated systems can also direct payments to and shift costs across subsidiaries to maximize revenue rather than improve the quality of care and health outcomes.

FIGURE 10

HOSPITALS OWN NEARLY HALF OF ALL PHYSICIAN PRACTICES

Trends on ownership / decline in private practice



Source: Carol K. Kane, “Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Non-Specialties,” American Medical Association, 2025. <https://www.ama-assn.org/system/files/2024-pp-pp-characteristics.pdf>.

Most research suggests that, rather than improving care, horizontal and vertical provider integration generally [raises prices for patients](#).⁴⁸ For example, two studies from 2024 found that hospital acquisitions led physicians to shift care toward hospitals and away from ambulatory surgery centers (which are often independent centers that compete with hospitals).⁴⁹ Systems may also encourage or require physicians to refer patients to other providers in the system as [a condition of system participation](#).⁵⁰

An area of vertical health system consolidation that deserves special attention is insurer ownership of the providers, facilities, and other health services that it pays. As previously described, individuals, groups like unions, and employers contract with health insurers to act on their behalf to organize payment and negotiate prices for healthcare. In theory, insurers are incentivized to lower prices to compete with other insurers for enrollees and employer health plans. However, these incentives are weakened—if not reversed—when the insurer dominates the market and owns some or all of the health service providers it pays, since subsidiary profits are the system’s profits. For example, when an insurer owns a PBM, it can increase system profits by steering enrollees toward its PBM’s preferred pharmacies, even if they are more expensive than other pharmacies. Such insurers are incentivized to generate revenue for its owned entities rather than reducing prices for its plan enrollees. One such area is the array of loopholes across the delivery system and billing practices.

A challenge for policy makers, regulators, and payers alike is understanding these multi-faceted organizational arrangements. The financial relationships within and across organizations are often hidden by incomplete corporate filings and disclosures as well as contractual clauses that block disclosure claiming trade secrets. For example, a [study of UnitedHealth Group](#) found it owns roughly 2,700 subsidiaries, some of which are holding companies that have no assets, employees, or easy explanation of purpose.⁵¹ This opacity is not limited to for-profit health corporations. Nonprofit health systems often [follow the practices](#) of for-profit systems, participating in a “race to the top” for commercially insured patients and revenue.⁵² For

example, Senator Tammy Baldwin [published a letter](#) in 2023 scrutinizing Ascension, a nonprofit healthcare system, for its for-profit investment activities and limiting its distribution of such proceeds into charity care.⁵³ Evidence suggests that nonprofit hospitals behave similarly to for-profit hospitals, with one study finding that nonprofit hospitals do not offer different amounts of charity care as a share of total expenses and have higher and faster-growing prices than for-profit hospitals.⁵⁴

CASE STUDY: UNITEDHEALTH AND MEDICAL LOSS RATIOS

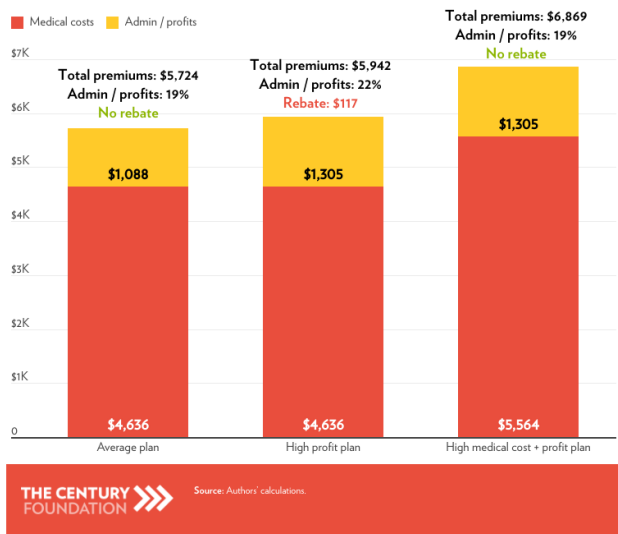
Policy makers have aimed to limit insurer profits through what are known as minimum medical loss ratio (MLR) requirements. For example, the ACA requires insurance companies to spend 80 to 85 percent of premium dollars on medical care and quality improvements, or issue rebates to its enrollees to make up the difference. Medicare requires MA plans to have an 85 percent MLR. However, insurers that own healthcare delivery providers can game the MLR requirement by paying higher rates to system-affiliated than other providers. These payments, including administrative costs and profits, are recorded as medical claims, which increase the insurer’s MLR and thus its ability to avoid rebates despite driving overall premiums up. Meanwhile, paying higher rates to system-owned providers improves their margins, which increases profits for the entire system.

A recent analysis of UnitedHealth Group illustrates the concerns with insurer-owned delivery systems. UnitedHealth Group owns the largest health insurance company in the country, UnitedHealthcare. It also owns Optum, which is the largest employer of physicians in the country (along with a PBM and other businesses). The analysis found that UnitedHealthcare paid Optum physician practices 17 percent more than non-Optum practices—and 61 percent more in areas where UnitedHealthcare’s market share was greater than 25 percent. The authors speculate that the risk of an insurer owing MLR rebates is lower when insurers have few competitors; in such an environment, insurers can [make higher payments](#) to the physician groups they own to avoid owing rebates, leaving enrollees not only with no rebates but also higher premiums (see Figure 11).⁵⁵

FIGURE 11

HOW INSURERS CAN AVOID PAYING REBATES BY INCREASING PAYMENTS

Illustration of how higher payments to insurer-owned providers can both increase profits and avoid medical loss ratio rebates for amounts above 20 percent of premiums



Private Equity in Health Systems

Beyond a growing set of connections within the health system, organizations outside of the health system have begun to acquire organizations in it, with revenue being exported as profits. Private equity firms use borrowed funds to acquire clinics, hospitals, and related organizations that are not listed on public stock exchanges. They then reorganize them, then sell them, and return profits to investors. Private equity investment in healthcare has been growing recently, with the share of physician practices and hospitals owned by private equity reaching 6.5 and 8.5 percent in 2024, respectively.⁵⁶ Research suggests that such acquisitions result in higher prices. For example, one study found that after a private equity firm that employed emergency physicians entered into contracts with hospitals, the prices paid to those emergency physicians [rose by 114 percent](#).⁵⁷ Another study documented that prices for several common dermatological services [rose by 3 to 5 percent](#) at acquired practices relative to prices at nonacquired practices, although prices for other services were not significantly affected.⁵⁸ There is no evidence of quality improvements associated with high prices, with one study [finding the opposite](#).⁵⁹

CASE STUDY: INDEPENDENT DISPUTE RESOLUTION FOR OUT-OF-NETWORK CARE

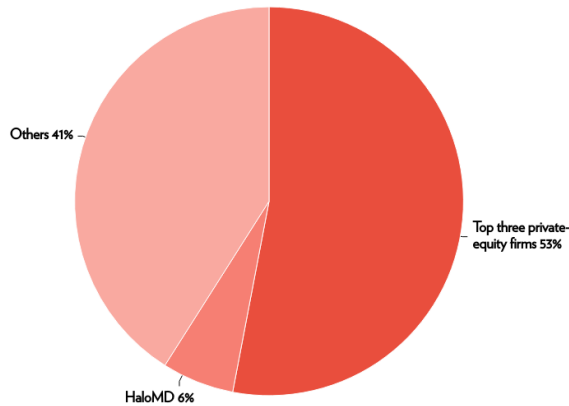
In 2020, Congress passed the No Surprises Act to protect consumers from unexpected (“surprise”) medical bills from providers for certain out-of-network services not fully covered by their insurance plans. These services were often received when a patient had an emergency visit to an in-network hospital but unknowingly saw an out-of-network provider, such as a radiologist. In these instances, patients were left to pay the (typically large) remaining balance between the provider’s charge and the payer’s out-of-network reimbursement amount. The No Surprises Act [prohibited insurers](#) and providers from engaging in surprise billing practices for most emergency services and some non-emergency services.⁶⁰

While the No Surprises Act successfully reduces surprise bills for patients, it has also created [new opportunities for skimming](#) through the independent dispute resolution (IDR) process.⁶¹ The IDR process was introduced to resolve disputes between insurers and providers about how much the provider should be paid for the out-of-network rate. However, the process has been dominated by private equity-owned intermediaries, which are paid by providers to file disputes and navigate the arbitration process on their behalf. One such company, HaloMD, has gamed the system to generate over [\\$1 billion a year](#) for providers through the IDR process.⁶² As a result, the IDR system has received more than ten times the number of expected disputes and added at least [\\$5 billion](#) to overall health system costs since it began in 2022.⁶³ (See Figure 12.)

FIGURE 12

MOST BILLING DISPUTES ARE INITIATED BY PROFIT-SEEKING ORGANIZATIONS

Initiating parties for federal out-of-network disputes, first quarter of 2023 to second quarter of 2024



THE CENTURY FOUNDATION  Note: The percentage of disputes initiated by profit-seeking organizations may be higher than 59 percent since some "others" may be in this category; as such, the estimate is conservative. Source: Matt McCough et al., "The Performance of the Federal Independent Dispute Resolution Process through Mid-2024," Peterson KFF Health System Tracker, May 29, 2025, <https://www.healthsystemtracker.org/brief/the-performance-of-the-federal-independent-dispute-resolution-process-through-mid-2024/>.

Policy Approaches

Tackling the complexity of the U.S. health system and the extra costs it generates is difficult. The financial interconnections of the system have evolved faster than the response of policy and regulation. As the case studies illustrate, policies designed as solutions may themselves have unintended consequences. The organizations that benefit from the complexity often argue that [the excessive revenue is necessary](#) to cross-subsidize other important activities such as unpaid time with patients, revenue-losing services such as neonatal intensive care and trauma care, and research and innovation.⁶⁴ Additionally, the health sector is the nation's largest employer and accounts for nearly one in five dollars in our economy.⁶⁵ Few systems are more entrenched.

That said, policy makers should feel compelled to reform the health system for two reasons: public demand, as well as the cost of doing nothing. In a recent survey, two-thirds of households [reported being worried](#) about being able to afford healthcare expenses, the highest share across a list of common household expenses including food, rent, and transportation costs.⁶⁶ Meanwhile, as the affordability of healthcare is diminishing, federal government spending on health care is projected to grow faster than overall health

expenditures and as much as 33 percent faster than the nation's economic growth over the next decade, based on Congressional Budget Office projections.⁶⁷

Here, we offer three approaches to policy to limit the skimming and complexity in the health system and explain how they would deliver cost savings to the federal government as well as other payers. These approaches are complementary and not mutually exclusive. And the policies are illustrative rather than concrete recommendations or a comprehensive plan. Their purpose is to stimulate further discussion and policy debate and development.

Policy makers could and should advance short-term and incremental changes that will limit skimming. But they should be clear-eyed that, without broader reforms that address consolidation, reduce complexity, and rethink coverage, they will be playing whack-a-mole against profit skimming forever, and American households will continue to pay the price and be saddled with increasingly unaffordable, ineffective, and inaccessible care.

Close Loopholes

Eliminating or reforming policies that permit excessive profits is important for program integrity and fiscal responsibility. Doing so also builds public trust in the government as an effective manager of the health system, which may matter in gaining support for expanding the government's role in health system oversight. Examples of policy changes based on the cases include:

- **340B Reform:** A bipartisan Senate working group has released a [discussion draft](#) that considers numerous 340B reforms.⁶⁸ These reforms would close some of the program's current loopholes by clarifying the program's intent, codifying contract pharmacy participation requirements, regulating hospitals' use of offsite clinics, and improving transparency and accountability, among other provisions. Congress could use federal savings to invest in key services that may have been cross-subsidized by the 340B program like trauma and maternity care.
- **Drug Patent Reform:** Multiple reforms have been

recently introduced in Congress to combat the ability for drug manufacturers to engage in patent gaming. For example, the bipartisan [Affordable Prescriptions for Patients Act](#) (S. 1041) would limit the number of patents a biologic drug manufacturer can use in litigation against companies seeking to produce a biosimilar drug in certain instances.⁶⁹ Additionally, the bipartisan [Preserve Access to Affordable Generics and Biosimilars Act](#) (S. 142) would limit the ability for manufacturers to enter into “pay-for-delay” deals, whereby brand-name drug manufacturers pay generic manufacturers to delay bringing their drug to market—a tactic that allows the brand-name manufacturer to maintain market exclusivity.⁷⁰ Reducing initial prices for brand-name drugs would reduce costs across all payers. Some federal savings could be invested in the National Institutes of Health or Food and Drug Administration to counter the industry’s claim about the impact on research and development.

- **Changes to Medicare Advantage Risk Adjustment Policy:** The [No UPCODE Act](#) (S. 1105) was introduced on a bipartisan basis in 2025.⁷¹ The bill would require Medicare to use two years of diagnostic data when calculating MA payments in its risk adjustment methodology and to prohibit the use of diagnoses from chart reviews or health risk assessments when calculating risk adjustment payments. Savings could be used to improve Medicare benefits for all its beneficiaries, in response to insurer arguments that reducing upcoding will lower the extra benefits they subsidize for their enrollees with it.

These are three of many patches to health system loopholes that have been proposed and are needed. And doing any of these could tangibly lower people’s health care costs. For example, [one analysis](#) estimated that reducing Medicare Advantage overpayments, including upcoding, could fund adding a dental, vision, and hearing benefit for all Medicare beneficiaries.⁷²

Limit and Reduce Consolidation and Financial Relationships That Exploit Loopholes

A second tranche of policy ideas would address the web of interorganizational relationships among healthcare suppliers that contribute to escalating costs without a corresponding increase in quality of care or outcomes. Longstanding laws overseen by the Federal Trade Commission and the U.S. Department of Justice, for example, are designed to protect the public against unfair trade practices by [preventing mergers and acquisitions](#) that create monopolies, but their ability to put brakes on health system consolidation has proven limited—at least until recently.⁷³ In the health sector, well-known policies include the Stark anti-kickback law and prohibition on physician-owned hospitals. Looking ahead, new or improved policy in five areas of focus could address the negative effects of interorganizational relationships:

- **Limits on Acquisitions and Ownership:** Policy makers at the federal and state level have increasingly considered stronger policies to prospectively limit mergers and acquisitions that increase horizontal and vertical consolidation, including those by private equity. States have also enacted a wide array of state transparency laws on ownership and mergers and acquisitions. For example, Connecticut, Hawaii, New Mexico, Oregon, Rhode Island, Vermont, and Wisconsin have given power to oversight agencies to [review and approve](#) hospital transactions.⁷⁴ On private equity, for example, the [Take Back Our Hospitals Act](#) (S. 4085) would make hospitals and nursing homes owned by private equity ineligible to receive Medicare funding.⁷⁵ Since Medicare is a large source of funding for providers, this would effectively ban private equity ownership of such facilities.
- **Breaking Up of Consolidated Organizations:** Some policy makers have proposed legislation that would break up already-consolidated organizations. At the state level, for example, Arkansas ([H.B. 1150](#)) prohibits PBMs from owning pharmacies.⁷⁶ Under the 2025 law, the state will not renew the licenses of existing pharmacies owned by PBMs. Similarly, Oregon ([S.B. 951](#)) strengthened the state’s corporate practice of

medicine rules by prohibiting overlapping ownership of management services organizations and physician-owned practices.⁷⁷ Any existing relationships must be restructured or unwound by 2029, with the effect of dismantling the predominant route private equity firms have used in the state to profit from relationships with physician practices. Proposals to break up consolidated healthcare entities have also been introduced at the federal level. For example, the [Patients Over Profits Act](#) (H.R. 5433) would, among other elements, require insurers to divest from ownership of medical practices.⁷⁸ Similarly, the [Break Up Big Medicine Act](#) (S. 3822) would prohibit any entity that owns a provider or management services organization from also owning an insurance company or pharmacy benefit manager.⁷⁹ The bill would require all entities who currently own more than one of these groups of entities to divest from one group of entities within a year.

- **Public Alternatives to Mergers and Private Equity for Funding and Management:** One reason that health providers turn to systems and private equity is due to the lack of other sources of capital and management support. Bolstering and improving public sources of support for healthcare providers could limit consolidation and corporatization. This could [include more public provisioning](#): government ownership or governance of medical and pharmaceutical production.⁸⁰ Similarly, policy makers have explored publicly run health plans over the years as an alternative to private plans, and some states, such as Colorado, Nevada, Oregon, and Washington, [have implemented them](#).⁸¹ Numerous federal proposals to expand Medicare have been proposed as well.⁸² These could either complement or substitute for private insurance plans, eliminating the incentive to skim through public ownership.
- **Oversight of Transactions:** An approach that could complement or supplement oversight of “organization charts” is to regulate the transactions or financial relationships between entities that drive up costs. Examples of such cost-inducing transaction clauses include “all-or-nothing” contracts that require insurers to include every hospital in a system regardless of need

or efficiency; and “most favored nation” contracts that require providers to [offer the insurer the lowest prices](#) they charge any insurer.⁸³ Some states have limited noncompete clauses and other mutually beneficial contractual arrangements that [drive up overall costs](#) rather than the value of care.⁸⁴

- **Oversight of Outcomes:** A different approach to limiting profit-driven interorganizational relationships would be to hold the system responsible for excessive costs. This could be done through stronger health insurance rate review authority. For example, one proposal would compare proposed annual premium increases to annual federal medical trend projections for the next year and deem any proposed premium increase above the trend [excessive and not approvable](#), directing insurers to lower the premium or withdraw from the market.⁸⁵ For self-funded plans not otherwise subject to rate review, a federal outcomes-based approach could clarify that the fiduciary duties of the plan include affordability for its enrollees—an issue that has [recently been litigated](#).⁸⁶ Policy could also increase the standards for providers’ nonprofit status. For example, Indiana [passed a law](#) in 2025 that would remove the nonprofit tax status and tax hospitals that charge above 250 to 300 percent of Medicare rates.⁸⁷

Policy makers tackling complex, consolidated health systems face some of the same challenges of regulating big technology and artificial intelligence (AI). Both sectors are already highly consolidated with incentives to consolidate further; are unfathomable to the typical policy maker, regulator, and person; and have value propositions that are hard to easily weigh against their costs. The major difference is that people mostly view technology and AI as commodities and healthcare as a public good.

While few cost analyses of the benefits of such actions have been published, one study estimates that enhanced antitrust enforcement of hospital mergers from 2010 to 2015, for example, could have [prevented a 5 percent increase](#) in hospital costs for privately insured people,⁸⁸ without which, private health insurance premiums would be significantly lower.

Simplify Health Coverage for Efficiency and Accountability

Policies can address skimming at the interstices of the system as well as in the organizational responses designed to capitalize on it. However, like the proverbial “whack-a-mole” problem, once one hole is filled, another one may pop open, and some profiteering company will be poised to exploit it. As such, policy makers should also consider shifting the public–private roles in the health system. If the government were to set the terms for coverage and payment for private providers and insurers, it could improve oversight, lessen the opportunities for loopholes, and limit the financial incentives to exploit them. If it were to do so fully, across all programs and payers, the result would be a Medicare-like system with various administrators and sources of funding. This could consist of:

- **Price and Profit Regulation:** The ability of health organizations to manipulate prices for profits, and the failure of competition to rein them in, is a [main driver](#) of high U.S. health spending.⁸⁹ Federal and state governments could increase their role in limiting prices and profits for providers, prescription drugs, and insurers. For example, states like [Maryland](#) and [Vermont](#) set rates for all payers of hospital services—commercial, Medicare, and Medicaid—to improve equity and affordability.⁹⁰ A growing number of [states](#) have benchmarked certain provider payments to Medicare to increase standardization, accountability, and efficiency.⁹¹ Setting upper price limits on what out-of-network providers can charge could also eliminate the ballooning problems from the No Surprises Act policy described earlier. When it comes to drug costs, pricing complexity could be reduced by forgoing PBMs and, instead, setting fixed administrative costs and dispensing fees, as has been done with [CalRx](#).⁹² Setting drug price ceilings through Medicare negotiated rates ([H.R. 6166](#)) or “most favored nation” policy ([S. 1818](#)) is also under debate.⁹³ In addition to prices, policy makers could cap profits. For instance, the current insurance company medical loss ratio requirement [could be changed](#) to apply to all plans (including self-funded plans) and set

the threshold for rebates on the administrative costs and overhead of more efficient plans in the Federal Employee Health Benefits Plan.⁹⁴ This would effectively put an upper bound on insurer profits.

- **Conflict-Free Utilization Control:** Federal and state governments could also intervene to limit skimming from excess utilization of healthcare as well as excessive prior authorization, denials, and appeals. Insurance companies manage these processes within some federal and state laws. In 2025 alone, eighteen states [took action](#) to standardize deadlines for prior authorization decisions, ensure decisions are made by clinicians, and make other process and substantive improvements.⁹⁵ One [federal proposal](#) would replace prior authorization with guidelines-based independent medical review.⁹⁶ Another way that insurers can manipulate utilization is through provider network design: by selection (for example, choosing providers based on potential profits rather than quality) and presentation (for example, making it challenging for patients to find covered providers, also known as “ghost networks”). In addition to proposals for network adequacy and transparency (for example, [H.R. 5281](#)), one proposal would [disintermediate insurance companies](#) from setting networks.⁹⁷ Instead, Medicaid, in this proposal, would set a single statewide network of participating providers, limiting private plans’ role to care management.
- **Radical Simplification of Coverage:** Another major area of confusion for people and oversight agencies is what benefits are covered and what cost sharing (for example, deductibles, copays) enrollees pay. Again, federal law [sets some standards](#) (for example, all private plans must cover prevention and have an annual out-of-pocket maximum).⁹⁸ Some states have gone further in their regulated markets to require coverage of certain benefits (for example, [infertility services](#)) and [standard cost sharing](#).⁹⁹ For example, [CoveredCA](#) only allows plans with standardized cost sharing to be offered through its health insurance marketplace.¹⁰⁰ Yet, even in government programs like Medicare and Medicaid, significant variation in benefits and cost sharing exists

depending on where an enrollee lives and what plan they choose. Creating clear rules for what is covered and how much people pay out-of-pocket would limit claims denials, surprise bills, and insurer cherry picking through benefit design (for example, excluding coverage of services used by people with high expenditures). This could—and arguably, should—align benefit and cost sharing policies across public and private coverage systems.

Each one of these simplifications would have independent and likely meaningful effects on the affordability of health coverage. To illustrate this: the Urban Institute estimated that capping commercial payment rates, relative to Medicare, to plus 15 percent for physicians and outpatient care and plus 60 percent for hospitals would reduce household premiums by [16 percent in 2024](#).¹⁰¹

Conclusion

The first step to solving the problem of cost in the U.S. health system is understanding its causes, not just its symptoms. This report aims to pull the thread from loopholes in the system to the agglomeration of relationships and organizations that exploit them. It explains how complexity, while not inherently problematic, has contributed to excessively expensive health care. The report also suggests approaches to policy that address these three areas: the loopholes, consolidation and profit-oriented relationships among suppliers, and the convolution that blocks visibility and accountability in the health system. In doing so, it aims to advance discussion, understanding, and proposals to address this multi-trillion-dollar system that puts health care at the top of the list of Americans' affordability concerns.

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