WRITE-OFF WARRIOR

PREYED ON:

How Insurance Corporations Are Bleeding Rural Hospitals and Communities to Death

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EXECUTIVE SUMMARY

The American heartland is under attack, preyed on by a profit-driven health insurance industry that is bleeding rural hospitals to death.

Exploiting loopholes in the federal Medicare Advantage program in particular, for-profit insurance corporations are killing community hospitals to pad their already-hefty profits.

Write-Off Warrior, a research and advocacy firm focused on supporting rural health systems, conducted a survey of 41 rural hospitals across the United States. Our findings reveal the extent to which health insurance corporations impose cumbersome approval processes for standard treatments, override physicians' recommendations, delay payments for weeks or months, or deny them altogether.

In addition, insurers take advantage of their outsized bargaining power to keep contract reimbursement rates below inflation, forcing cash-strapped hospitals to shoulder ever-growing, unsustainable financial burdens.

Three quarters of rural hospital leaders surveyed cited Medicare Advantage as the most challenging insurance payer. Corporate insurer practices under the Medicare Advantage program have destabilized the financial health of community hospitals, forcing them to reduce or eliminate vital services such as mental health and rehabilitation care. Many rural hospital leaders worry they will soon join the scores of peers who have already closed their doors in the past two decades.

At the same time, insurance corporations continue to push costs onto patients in the form of high deductibles and copays, which hospitals are forced to collect. This pits struggling patients against strapped rural health care providers while obscuring the real villain: profiteering insurance companies.

It's time to sound the alarm on these modern-day Draculas. Time to reform a monstrous system that is doing grave harm to the American heartland.

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INTRODUCTION

Sounding the Alarm on a Monstrous Payer System

Rural hospitals are fighting for their lives, grappling with a health insurance payment system that is bleeding them dry. In the American heartland, where community hospitals are the backbone of small-town health and stability, insurance corporations wield their power to catastrophic effect.

These insurance corporations have transformed the Medicare Advantage program in particular into a tool of exploitation, ripping off those serving and living in some of our most vulnerable communities. Instead of supporting rural health systems, insurance corporations enrich themselves by imposing burdensome approval processes, denying coverage for vital treatments, delaying or declining to provide critical payments, and pushing more costs onto patients through skyrocketing deductibles and copays.

The result is that the rural healthcare system is in crisis. Over the past two decades, almost 200 rural hospitals have closed, and more than 700 – over 30% of all rural hospitals in the country – are now at risk of closure due to financial instability.[1] These closures affect more than the hospitals themselves; there are devastating ripple effects across entire regions, leaving patients without access to care and local economies in jeopardy.

When rural hospitals die, heartland communities are wounded as well – damage that can threaten America's overall energy and food systems and our nation's disaster preparedness.

Meanwhile, insurance corporations continue to post record profits. In 2023 alone, the top six insurers raked in over $41.7 billion in profits – up from $5.4 billion in 2003.[2]

Much of their profit and business growth comes through the Medicare Advantage program.[3] And that is where we created a monster – or, more accurately, many corporate monsters. Monsters that are effectively stealing from taxpayers and devouring rural hospitals and communities.

1. Center for Healthcare Quality and Payment Reform. (2024, November). *Rural hospitals at risk of closing.* https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
2. Figures compiled from SEC filings accessed through the EDGAR database. See Appendix A for a detailed breakdown of individual company profits.
3. Ortaliza, J., Fuglesten Biniek, J., Hinton, E., Neuman, T., Rudowitz, R., & Cox, C. (2024, July 2). *Health insurer financial performance in 2023*. KFF. https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

Traditional Medicare is a health insurance program for senior citizens and people with disabilities, funded by U.S. taxpayer dollars and taxpayer contributions over a lifetime of work. Through the Medicare Advantage program, these taxpayer funds flow not to Medicare, but to private insurance corporations, which are then supposed to reimburse hospitals for patient treatments.

Medicare Advantage for All?

There are serious concerns the new administration will expand the very program that rural hospital leaders say hurts their communities.

In November 2024, President Donald Trump selected TV personality and heart surgeon Dr. Mehmet Oz to lead the Centers for Medicare and Medicaid Services (CMS). CMS oversees health insurance programs covering more than 150 million Americans, including the Medicare program and its for-profit offshoot, Medicare Advantage.

Oz has proposed expanding Medicare Advantage to all Americans, not just seniors. In a 2020 article, Oz called this approach to universal coverage "Medical Advantage." [4]

But to whose advantage? Rural hospital leaders and other health care advocates believe Oz's plan would only further enrich for-profit insurance behemoths while continuing the harm Medicare Advantage is already doing to rural communities.

Though Oz has yet to be confirmed, even his nomination signals a worrisome focus on the interests of health insurance corporations over the basic needs of patients.

4. Halvorson, G., & Oz, M. (2020, June 11). Medicare Advantage for all can save our health care system. *Forbes*. https://www.forbes.com/sites/steveforbes/2020/06/11/medicare-advantage-for-all-can-save-our-health-care-system/

Federal law enables Medicare Advantage providers to require prior authorization for a range of services. But rural hospital leaders told us insurance companies are violating the spirit of the law by requiring approvals for routine procedures and frequently denying medical treatments that physicians deem necessary. In practice, insurance corporations keep their costs low and profits high by delaying and denying needed care.

In our survey, 75% of rural hospital leaders – 31 out of 41 – singled out Medicare Advantage plans as their most challenging insurance payer.

Problems with payments from Medicare Advantage plans and hardball rate negotiation tactics have direct impacts on patient care, rural hospital leaders told us. Hospitals have cut services such as maternity care, rehabilitation, and mental health services; put off facility upgrades; and limited staff pay increases – which means difficulty attracting and retaining great talent.

Rural hospitals are fighting for their lives. It's the tale of Count Dracula, who lived in his well-appointed castle while gradually devouring the nearby community. A health insurance industry dripping with profits and armed with lobbyists is quietly sucking the life blood out of rural hospitals and their communities.

If we don't act, more rural hospitals will close, more patients will suffer and die, and our nation's heartland will be left further behind. It's time to end these insidious practices and demand a better future for rural healthcare.

Sick in the Heartland – and Beyond

The U.S. healthcare system lags behind that of other developed nations, most of whom do not give so much power to for-profit insurance companies.

America's heartland is part of a nationwide health system that is far less healthy than those of our peers across the globe. The United States scores the lowest of 10 developed countries on equity, access to care, and health outcomes, according to The Commonwealth Fund. The Commonwealth Fund's report, "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System," also found that the U.S. scored lowest overall.[5]

This poor performance is especially notable because the U.S. spends the most on health care as a percentage of the overall economy. Health care spending makes up 16.5% of GDP in the U.S. This is nearly double what top-ranking nation Australia spends – 9.8% of GDP.

What's more, when Americans receive medical care, they often take on medical debt. Although 90% of Americans have some form of health insurance, 20 million people now owe medical debt. A 2023 survey found that 70% of Americans feel failed by the U.S. healthcare system.[6]

Businesses also are hurt by the high costs of premiums and deductibles in the U.S. And economists worry that rising healthcare costs – they have more than doubled as a percentage of GDP since 1980 – strain the overall economy and make it less stable.

Why is America's healthcare system so sickly, in the heartland and beyond? Observers point to multiple factors, including malpractice lawsuits as well as higher levels of obesity and drug abuse compared to other nations. But the main difference between America and its healthier global peers is a health system that puts for-profit insurance companies at the center.

5. Tikkanen, R., Abrams, M. K., & Schneider, E. C. (2024, September). *Mirror, mirror 2024: A portrait of the U.S. health system.* The Commonwealth Fund. https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024
6. Ducharme, J. (2023, May 15). Americans are losing faith in the U.S. health care system. *Time*. https://time.com/6279937/us-health-care-system-attitudes/

METHODOLOGY

A National Rural Hospital Survey on Insurance Corporation Impacts

Write-Off Warrior's 2025 National Rural Hospital Survey was designed to discover how insurance corporation practices are affecting community hospitals.

We reached out to several dozen rural hospitals across the United States, and received responses from leaders at 41 hospitals. These institutions spanned 15 states, representing most regions of the country:

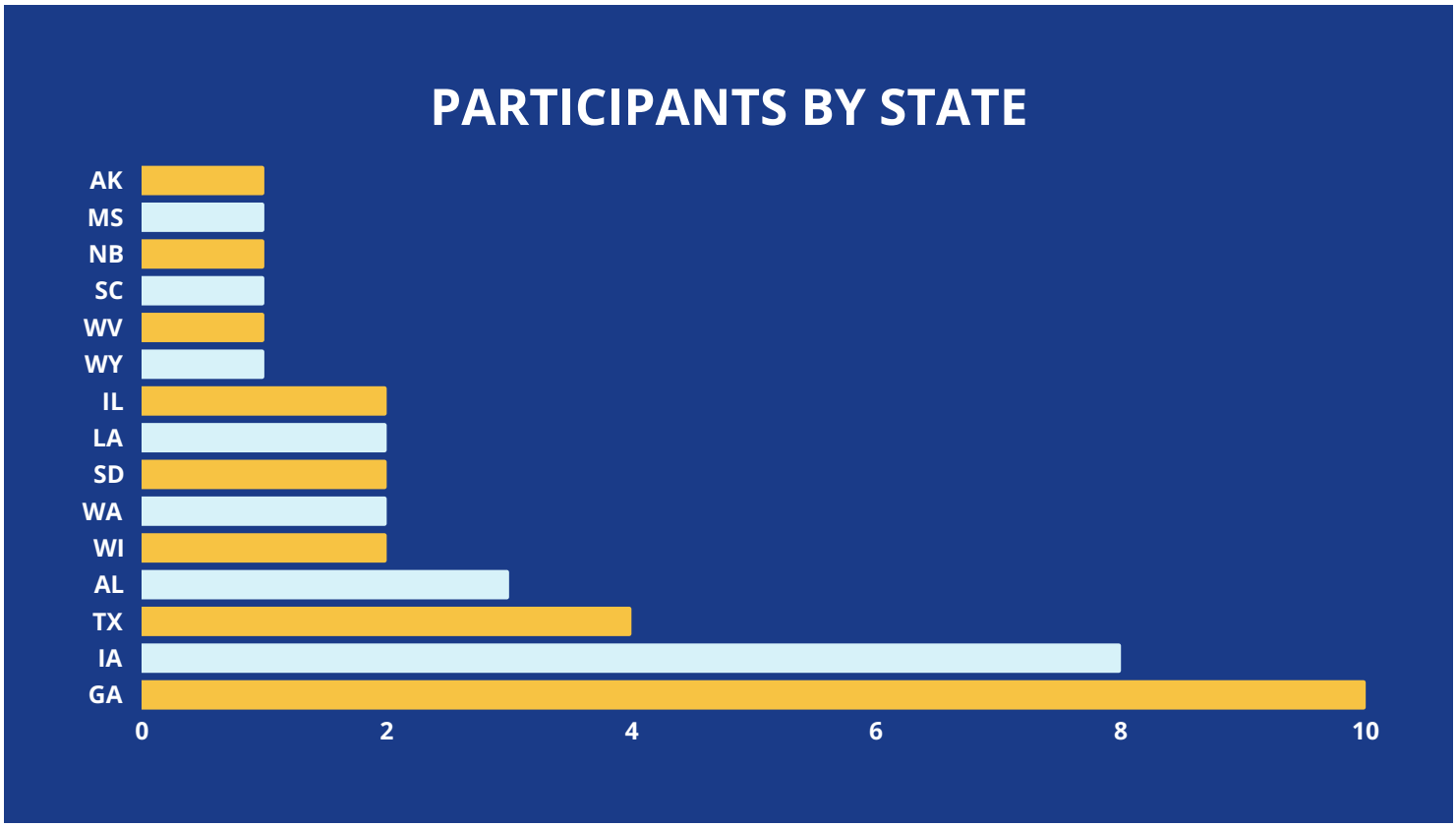

Fig. 1. Number of survey respondents by state.

We heard from leaders with a variety of executive-level titles:

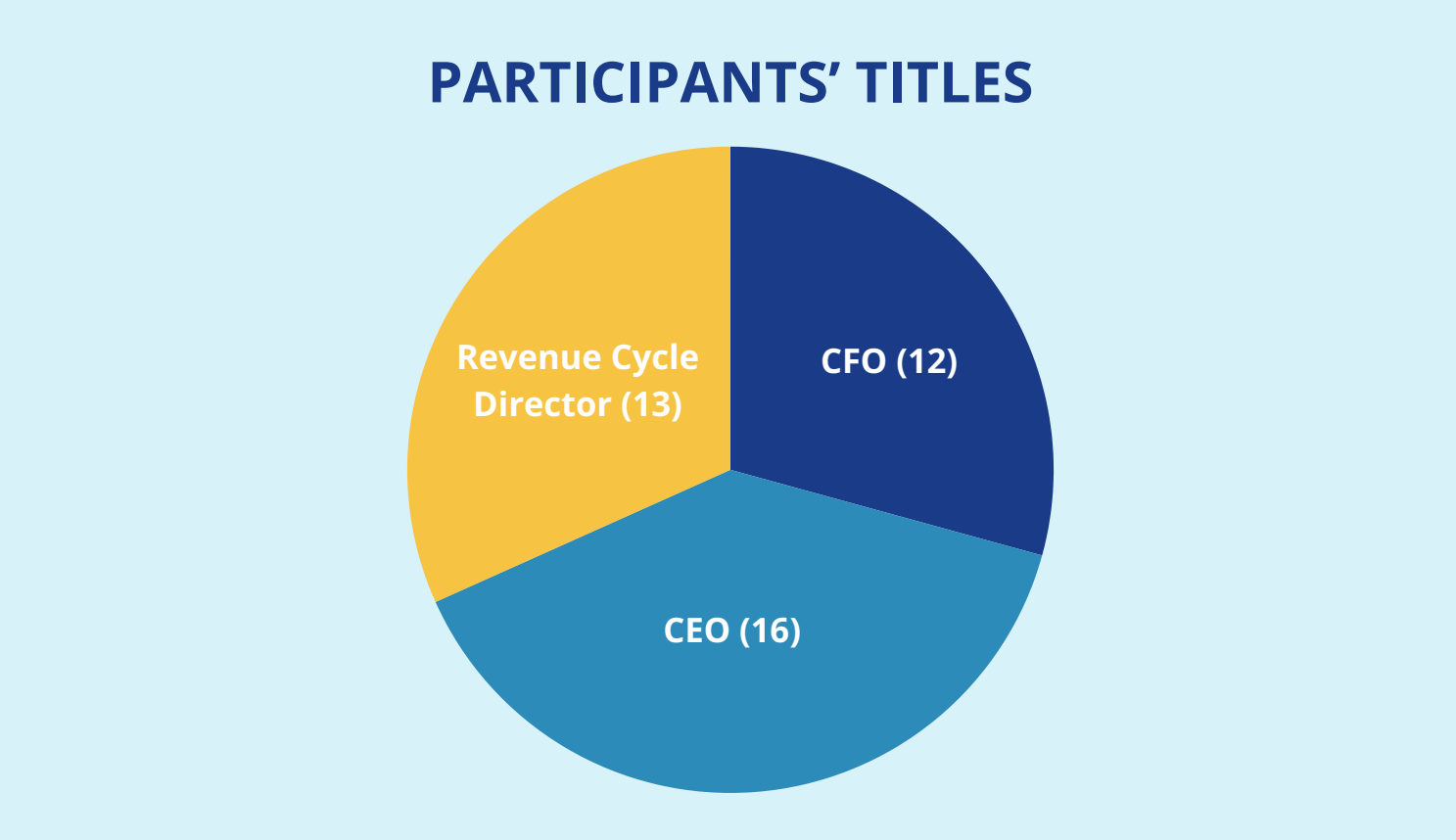

Fig. 2. Survey respondent titles, reflecting leadership positions.

The survey consisted of two sections:

Hospital overview: This section gathered basic information about the hospital.

Insurance corporation impact assessment: This section explored the ways that insurance policies affect the hospital, patients, and surrounding community. It included 15 questions, a mix of multiple choice and open-ended response.

While some respondents completed the survey online, the majority provided answers through phone interviews. In some cases, we followed up to gather additional details and illustrative examples.

WHY RURAL HOSPITALS MATTER

Shaping the Well-Being of Americans Nationwide

Rural hospitals are far more than healthcare providers. They are the backbone of their communities and beyond. They deliver essential medical services to populations spread out across vast areas, often serving as the only accessible provider for entire regions. In addition to healthcare, rural hospitals support local businesses, sustain jobs, and foster community stability.

As the American heartland wrestles with a range of social and economic challenges, rural hospitals often act as a safety net and serve as a source of pride.

Despite their vital role, rural hospitals are uniquely vulnerable to financial instability. They operate on razor-thin margins in part because of lower patient volumes compared to urban hospitals. Their patient base often includes a higher percentage of individuals covered by Medicaid, the federal program that insures low-income Americans.

Rural areas also have a higher proportion of older adults eligible for Medicare. Medicare and Medicaid typically reimburse hospitals at lower rates than employer-provided private insurance plans.

When rural hospitals close, the wider effects are profound.

In addition, many rural patients have high-deductible plans or lack healthcare coverage altogether and can't afford to pay for treatments out of pocket – leading to losses for hospitals that care for them. These financial pressures are compounded by rising operational costs, workforce shortages, and an aging population that requires more complex care.

Rural hospitals also play a key role in addressing alarming health disparities. Rural Americans, who make up roughly 20% of the U.S. population, are more likely to die prematurely from heart disease, cancer, stroke, and respiratory conditions compared to their urban counterparts. They face higher rates of chronic illnesses such as diabetes and obesity, and are at greater risk of fatal car accidents, drug overdoses, and mental health challenges.[7] Yet, access to quality care is limited and getting worse, leaving many rural residents with fewer options for managing their health.

Further, rural hospitals serve a broader national purpose, as heartland communities are critical to America's food and energy security. They produce the majority of the country's agricultural output and play a key role in energy production, from oil and gas to renewable resources. The stability of these communities directly affects urban areas by providing consistent food supplies and energy access while minimizing price volatility. Without healthy rural populations and functioning hospitals, these essential systems are at risk.

RURAL HOSPITALS AT IMMEDIATE RISK OF CLOSING

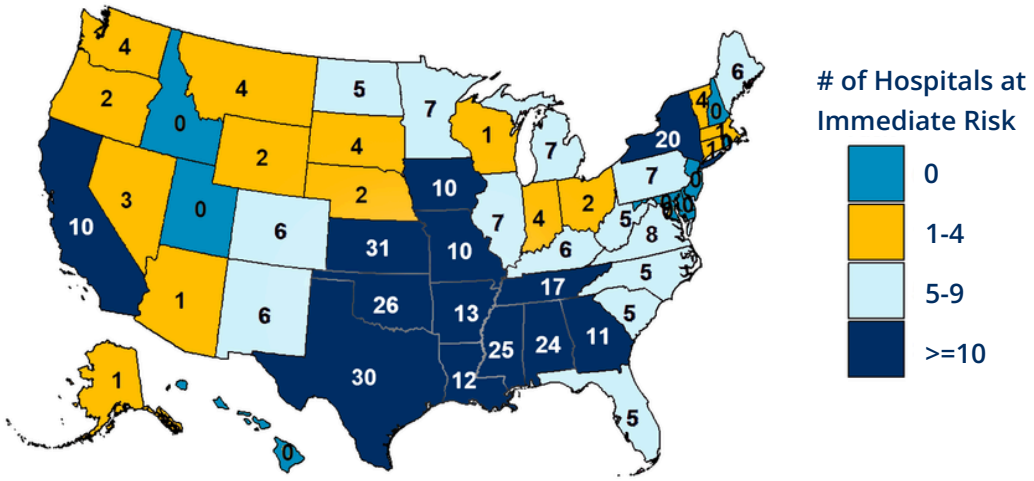

Fig. 3. Rural hospitals at immediate risk of closing. These hospitals are expected to survive 2-3 more years at most. [8]

When rural hospitals close, the wider effects are profound. Residents lose access to timely medical care, emergency response times increase, and local economies falter. The death of a rural hospital can start a downward spiral, leading to an exodus of residents and wider malaise in the heartland. Every closure is a blow to the health, safety, and future of the surrounding community – and the nation as a whole.

7. Centers for Disease Control and Prevention. (2024, May 16). *About rural health.* U.S. Department of Health and Human Services. https://www.cdc.gov/rural-health/php/about/index.html
8. Center for Healthcare Quality and Payment Reform. (2024, December). *Rural hospitals at risk of closing*. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

RURAL HOSPITAL CEOs SPEAK OUT

As we surveyed leaders of rural hospitals, we were struck by their frustration and deep concern for their communities. Here are the stories of several CEOs struggling to serve their rural regions amid exploitative insurance industry practices.

Platte Health Center Avera in South Dakota: "That safety net is threatened."

Mark Burket is CEO of Platte Health Center Avera, a 17-bed facility that serves the 1,300-person city of Platte and surrounding communities in southeast South Dakota.

Like many leaders of rural hospitals, a strong sense of mission inspires Mark. As he navigates obstacles including talent attraction difficulties, supply shortages, and inflation, a commitment to community members keeps him and his team going.

"At the end of the day, do not lose sight of the bigger picture and why we put up with challenges," Mark says. "The motivator is the patient – which is always worth the effort."

Mark and his team have had to increase their efforts in recent years, mostly because of corporate insurance payers. Platte Health Center Avera is experiencing **higher rates of treatment denials, payment delays, and inflexibility on contract terms**.

Mark says insurance corporation pressure on the hospital's operating margins is making it more challenging to continue programs like diabetic education, behavioral and mental health services, and long-term care services.

> **We're a community-focused hospital…It's just getting a lot more difficult.**

One of his biggest concerns is the expansion of Medicare Advantage plans. Television ads and other marketing campaigns touting these plans are often misleading. The ads target older Americans and highlight perks like grocery benefits, vision, and dental care.

However, what's not immediately apparent in the ads are the many downsides to these plans, including the need for pre-approvals for procedures, as well as co-pays for some inpatient treatments that would be entirely covered by traditional Medicare.

One of his biggest concerns is the expansion of Medicare Advantage plans.

"It's the phone calls and TV commercials," Mark says. **"Patients really have no idea what they're getting."**

Mark told us the story of an 87-year-old patient we'll call Judith, who was hospitalized for a procedure. When the hospital viewed her insurance, there was a change from traditional Medicare – she now had a Medicare Advantage plan. Judith was devastated to learn she had a co-pay of $300.00.

"She was just in absolute tears," Mark says. "She says, 'I can't afford that. I don't have that much money.'"

Mindful that the stress was affecting her health, Mark used a patient assistance fund to cover what he could and wrote the rest off.

He wonders how much longer rural hospitals like his can survive and support patients like Judith.

"We're a community-focused hospital," Burket says. "We are that safety net – above and beyond even healthcare services – to rural communities. That safety net is threatened. **It's just getting a lot more difficult.**"

RURAL HOSPITAL CEOs SPEAK OUT

Miller County Hospital in Georgia: Corporations "are now the drivers of healthcare, rather than the doctors."

Robin Rau is CEO of Miller County Hospital, a 25-bed hospital in Colquitt, a rural community in southwest Georgia.

Robin takes pride in her award-winning organization, but says insurance company practices are threatening the quality of care and viability of rural hospitals.

"They're now the drivers of healthcare, rather than the doctors," Robin says. "**They're deciding everything**."

> ***For-profit corporations are increasing their bottom line by denying critical care to patients.***

Miller County Hospital has taken the dramatic step of refusing to accept some forms of health insurance for non-emergency care. Robin and her team work to inform local residents of the consequences of different health insurance plans.

Robin understands the original impulse behind managed care and the Medicare Advantage program. Doctors and hospitals may have ordered unnecessary tests and procedures at times, generating excess costs. But the pendulum has swung far too much in the other direction. For-profit corporations are now increasing their bottom line by denying critical care to patients, Robin says.

"We thought the hospitals and doctors were driving everything so that we could line our pockets, right?" she says. "So we **took all the control away from doctors and from hospitals, and now we put it into Fortune 500 companies.**"

RURAL HOSPITAL CEOs SPEAK OUT

Taylor Regional Hospital and Bleckley Memorial Hospital in Georgia: "It will lead to a national bed shortage."

Jon Green is CEO of Taylor Health Care Group, which operates two hospitals in rural central Georgia: Taylor Regional Hospital in Hawkinsville and Bleckley Memorial Hospital in Cochran.

Insurance industry pressures have already led Jon to shutter key services, and he worries **our flawed health care payment system threatens the nation's ability to handle the next pandemic**.

As a small, non-profit healthcare organization, Taylor Health struggles to negotiate favorable reimbursement rates with insurance companies. What's more, **Jon finds that Medicare Advantage plans deny 50% or more of his hospitals' claims** for payment.

All this is happening at a time when labor costs have jumped 40% in recent years, and the prices of some supplies have increased 300%.

The result is ever-greater budget challenges. Jon had to close an obstetrics-gynecology unit six years ago, and more recently he shut down an intensive care unit.

"**We pretty much lose money on every [insurance] payer that we have right now**," Jon says. "Reimbursement rates have not changed, but supplies and labor have skyrocketed in cost."

As rural hospitals cut back operations to keep from bleeding more red ink, Jon says, **we face a loss of acute-care resources nationwide**. In effect, insurance companies are squeezing rural hospitals to the point of putting the country at risk for when the next Covid-like crisis hits.

"It will lead to a national bed shortage," Jon says.

RURAL HOSPITAL CEOs SPEAK OUT

Jeff Davis Hospital in Georgia: "Are we going to [become], basically, band-aid stations?"

Barry Bloom is CEO of Jeff Davis Hospital, a 25-bed hospital in Hazlehurst, a rural community in southeast Georgia. Last year, his organization dipped into the red for the first time in seven years.

And he says the hospital may run at a loss again this year, thanks in large part to the impact of Medicare Advantage plans and other insurance industry practices.

Barry is no slouch when it comes to managing a hospital's finances. Under his leadership, Jeff Davis's annual budget rose from $29 million in 2018 to roughly $90 million this past year. But his costs have been growing faster, in part because **he now has to pay a consultant to handle all the claim denials and reimbursement disputes** with insurance payers.

Are rural facilities going to be able to survive as independent hospitals?

Part of the challenge Barry faces is the difficulty of negotiating reimbursement rates with insurance companies that allow the hospital to cover its costs.

Barry says the big corporations often seek to change the terms of the deals, in ways that **put more money in the insurers' hands**.

Barry and his board of directors are facing a decision no rural leader wants to confront. As **giant insurance players siphon more and more dollars from small rural hospitals**, can the local health center remain viable? And if not, will merging with a larger system mean a **serious drop in quality of care** for the community?

"We have to ask whether at some point rural facilities are not going to be able to survive as independent hospitals," Barry says. "Are we going to go to that scenario of being, basically, band-aid stations?"

RURAL HOSPITAL CEOs SPEAK OUT

Avera Merrill Pioneer Hospital in Iowa: "There's no way that it should take 14 to 30 days to review a chart."

Craig Hohn is CEO of Avera Merrill Pioneer Hospital, an 11-bed hospital in Rock Rapids, Iowa. For Craig, serving his rural community requires constant struggle against insurance companies.

Craig often sees patients with Medicare Advantage plans **forced to wait two to four weeks to be approved for routine treatments** that would be automatically covered by traditional Medicare.

These extended approval periods prevent the hospital from seamlessly moving a patient with a hip replacement from a surgery recovery bed to a less-intense level of care for rehabilitation services. The red tape means Craig's **critical care resources are tied up** for weeks at a time.

Medicare Advantage approvals can also force patients to face a dilemma: possibly have to pay for care out of pocket or delay needed care.

What's more, **clinicians often find themselves pulled away from their patient care duties** to speak on the phone with insurance companies that challenge treatment recommendations. In many cases, Craig says, the providers have to repeat information already shared with the insurance payer through official forms.

These Medicare Advantage delays and denials have Craig on a crusade.

Serving the rural community requires constant struggle against insurance companies.

"There's no way that it should take 14 to 30 days to review a chart," he says. "I'm going to keep beating this drum."

EXPLANATION OF NON-BENEFITS

The PR playbook insurance corporations use to justify exploitative policies, including the Medicare Advantage program

Health insurance payers have long rationalized their harmful policies and practices with three fallback excuses. However, none of them hold water, and it's time we called them out.

1 "Cost Sharing."

Claim: High deductibles and copayments turn Americans into conscious consumers. With "skin in the game," people will avoid over-using health care services – the "moral hazard" argument. Ultimately, cost-sharing will reduce premiums and healthcare costs by decreasing utilization.

Reality: Deductibles and cost-sharing burdens overall have increased faster than workers' wages.[9] What's more accurately called "cost-shoving" often deters people from seeking necessary care. Big deductibles and copays have saddled millions of Americans with medical debt.[10] What's more, high costs disproportionately affect people who most need care and people from marginalized populations.[11]

2 **Medicare Advantage:** Choices.

Claim: The Medicare Advantage program gives U.S. seniors more choices in their health coverage. There are a large number of plans – close to 4,000. Overall, consumers give high satisfaction ratings to the plans. The plans also offer benefits not covered by traditional Medicare, such as vision, dental, and hearing services.

Reality: Studies have found that Medicare Advantage plans often mislead consumers.[12] Insurers fail to meaningfully disclose downsides like scant vision and hearing benefits, pre-authorizations that can delay or prevent care, and limited medical networks – especially in rural areas. Also, sicker patients leave Medicare Advantage for traditional Medicare at a higher rate, even though it can be challenging for seniors to make this switch.[13]

3 Medicare Advantage: Effectiveness and Efficiency.

Claim: Medicare Advantage reduces fraud and eliminates waste. Medicare is one of the largest government programs, costing U.S. taxpayers roughly $1 trillion, and it has experienced significant levels of fraud. The private, for-profit insurance companies offering Medicare Advantage keep costs down and quality up through strict credentialing of healthcare providers and pre-authorizations of treatments.

Reality: Research has failed to prove that Medicare Advantage is more effective than traditional Medicare in terms of health outcomes.[14] Nor has Medicare Advantage cut costs – in fact, the opposite has occurred. The government's own watchdog agency found Medicare Advantage to cost taxpayers 22% more than traditional Medicare.[15] What's more, a 2024 *Wall Street Journal* series of articles found insurance companies effectively ripping off taxpayers through the Medicare Advantage program in multiple ways. These include adding unnecessary diagnoses to Medicare Advantage patients, "leading to billions of dollars in extra government payments to insurers."[16] Eliminating Medicare Advantage is estimated to generate between $88-140 billion – roughly enough to add dental, vision, and hearing benefits to the traditional Medicare program.[17]

9. Peterson-KFF Health System Tracker. (2023, October 4). *Increases in cost-sharing payments have far outpaced wage growth*. https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/
10. Peterson-KFF Health System Tracker. (2022, March 10). *The burden of medical debt in the United States*. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/
11. Center on Budget and Policy Priorities. (2023, March 23). *Building on the Affordable Care Act: Strategies to address marketplace enrollees' health care affordability*. https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees
12. KFF. (2023, October 18). *KFF research shows that Medicare open enrollment TV ads are dominated by Medicare Advantage plans featuring celebrities, active and fit seniors, and promises of savings and extra benefits without fundamental plan information*. https://www.kff.org/medicare/press-release/kff-research-shows-that-medicare-open-enrollment-tv-ads-are-dominated-by-medicare-advantage-plans-featuring-celebrities-active-and-fit-seniors-and-promises-of.savings.and.extra.benefits.without.fund/
13. Physicians for a National Health Program. (2024, May 23). *Taking advantage: How Medicare Advantage plans overcharge taxpayers while delaying and denying care to seniors*. https://pnhp.org/taking-advantage/#executive-summary
14. KFF. (2024, March 13). *A review of 62 studies finds few big differences between traditional Medicare and Medicare Advantage on a variety of measures*. https://www.kff.org/medicare/press-release/a-review-of-62-studies-finds-few-big-differences-between-traditional-medicare-and-medicare-advantage-on-a-variety-of-measures/
15. Medicare Payment Advisory Commission. (2024, March). *Report to the Congress: Medicare payment policy*. https://www.medpac.gov/wp-content/uploads/ 2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC.pdf
16. Herman, B., & Evans, M. (2024, December 29). UnitedHealth's Army of Doctors Helped It Collect Billions More From Medicare. *The Wall Street Journal*. https://www.wsj.com/health/healthcare/unitedhealth-medicare-payments-doctors-c2a343db
17. Physicians for a National Health Program. (2024, March 12). *Our payments, their profits*. https://pnhp.org/news/ our-payments-their-profits/

FROM PROPAGANDIST TO WHISTLEBLOWER

A former Cigna executive says insurers prioritize shareholders over patients

Wendell Potter is intimately familiar with the deceptive rhetoric of the health insurance industry. From 1999 to 2008, he headed corporate communications at insurance giant Cigna. While there, he helped roll out the concept of "consumerism" – the basis of pushing more and more costs onto patients.

The death of a 17-year-old girl after Cigna initially denied her care coverage was the biggest factor prompting Wendell to quit. His conscience couldn't take it anymore. Today, he considers himself a reformed insurance propagandist and works as a whistleblower against exploitative industry practices.

Wendell is the author of *Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR Is Killing Health Care and Deceiving Americans*. He also is the president of the Center for Health and Democracy and writes the newsletter "HEALTH CARE un-covered."

"All of the tactics used by the oil, beverage, and banking industries to influence lawmakers at every level of government were pulled straight from the cigarette makers' playbook," Wendell writes.[18]

"Distract people from the real problem; generate fear; split communities with rhetoric, pitting one group against another; encourage people to doubt scientific conclusions; question whether there really is a problem; and say one thing in public while working secretly to do the opposite."

Wendell's words capture the way the insurance industry overstates health care fraud, exaggerates the extent to which medical providers drive up healthcare costs, scares Americans about unsafe medical practices, and minimizes research that undermines the Medicare Advantage program.

In a December 2024 *New York Times* opinion article, Wendell noted that UnitedHealthcare cancelled a meeting for investors and Wall Street financial analysts in the wake of CEO Brian Thomson's killing. Such events are telling, Wendell wrote:

"These annual investor days, like the consumerism idea I helped spread, reveal an uncomfortable truth about our health insurance system: that shareholders, not patient outcomes, tend to drive decisions at for-profit health insurance companies." [19]

18. Potter, W. (2013). *Deadly spin: An insurance company insider speaks out on how corporate PR is killing health care and deceiving Americans*. Bloomsbury Press.
19. Potter, W. (2024, December 18). I was a health insurance executive. What I saw made me quit. *The New York Times*. https://www.nytimes.com/2024/12/18/opinion/health-insurance-united-ceo-shooting.html

SURVEY FINDINGS

What more than 40 rural hospital leaders told us about the way insurance company policies affect their hospitals and patient care.

Fig. 4. Which payer is the most challenging to work with?

Medicare Advantage plans, offered by several insurers, emerged as the most significant challenge for rural hospitals, with 31 out of 41 respondents highlighting their negative impact.

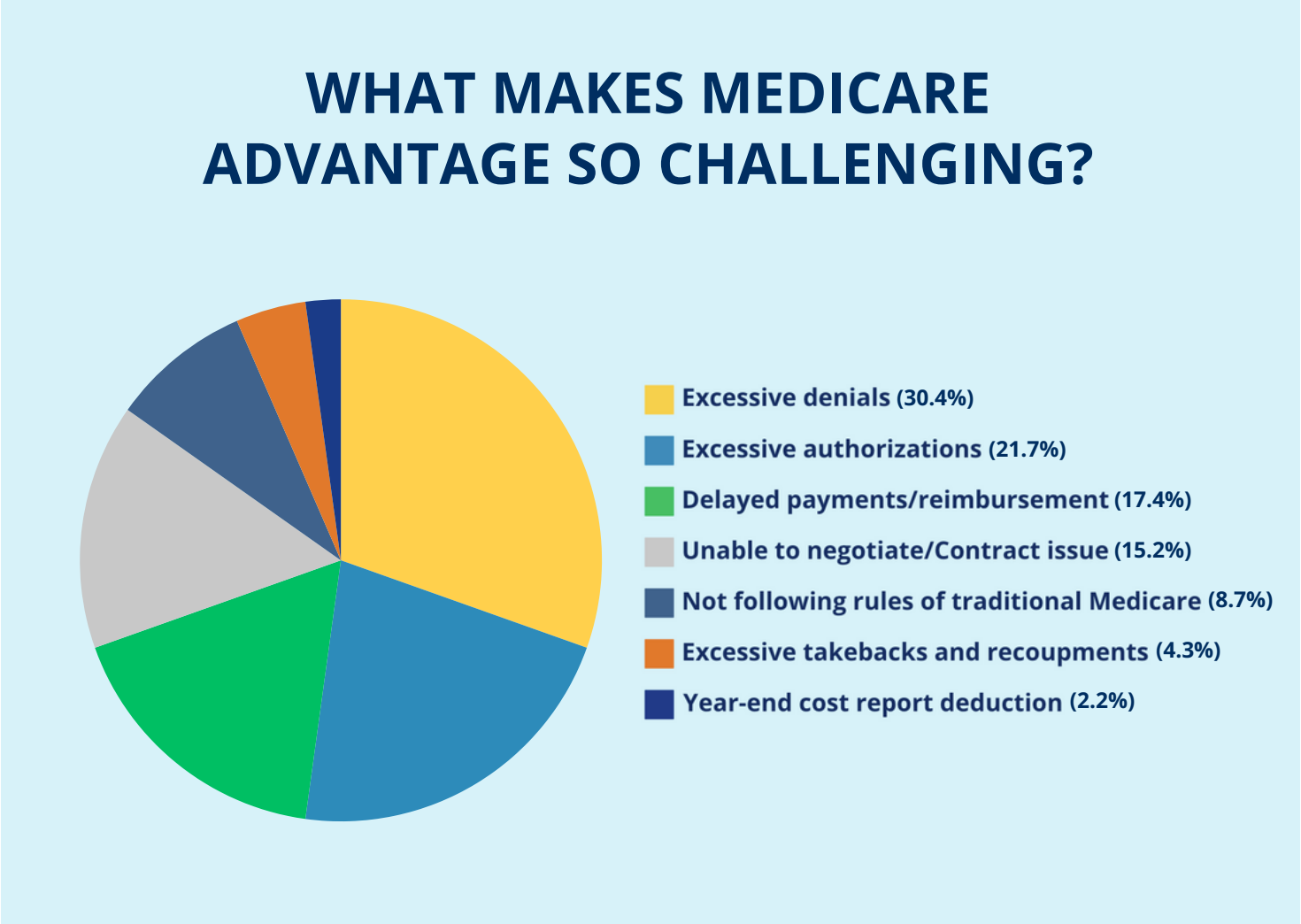

Fig. 5. What make Medicare Advantage so challenging?

Medicare Advantage plans create a range of challenges for rural hospitals. Excessive denials, delayed payments, and burdensome authorizations – shown here as the most prevalent issues – strain already-limited resources and jeopardize care delivery. See infographic on p. 31 for details on the ways Medicare Advantage plans harm rural hospitals.

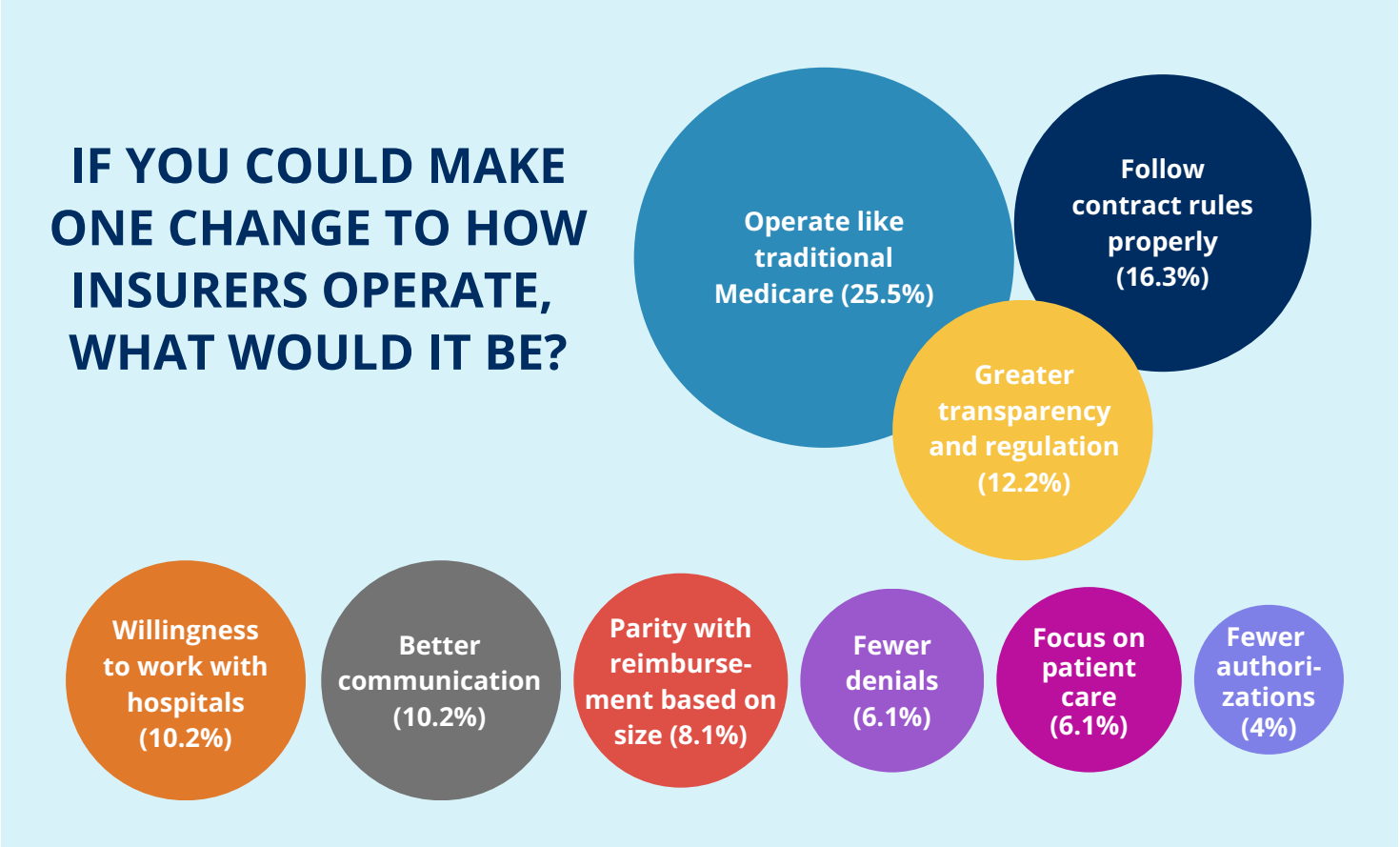

Fig. 6. If you could make one change to how payers operate, what would it be?

Traditional Medicare operates with clear rules, predictable reimbursements, and a commitment to covering medically necessary services without excessive hurdles. In contrast, Medicare Advantage plans introduce prior authorizations, opaque contract negotiations, and frequent denials that complicate care delivery and strain hospital resources.

The overwhelming preference among rural hospital leaders is for Medicare Advantage plans to "operate like traditional Medicare," reflecting the deep frustrations and obstacles to care caused by the profit-driven model of these plans.

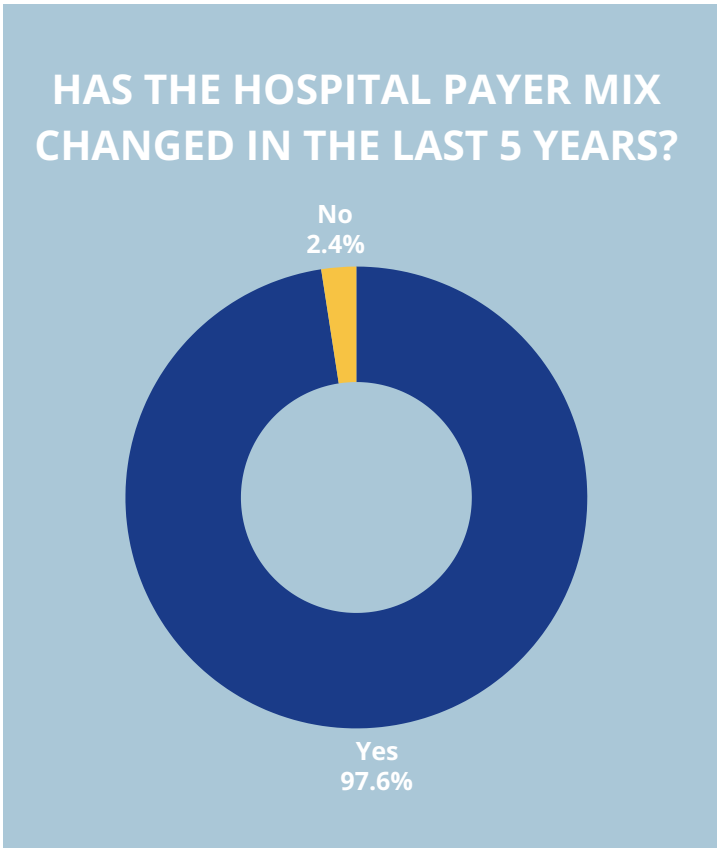

Fig. 7. Has the hospital payer mix changed in the last 5 years?

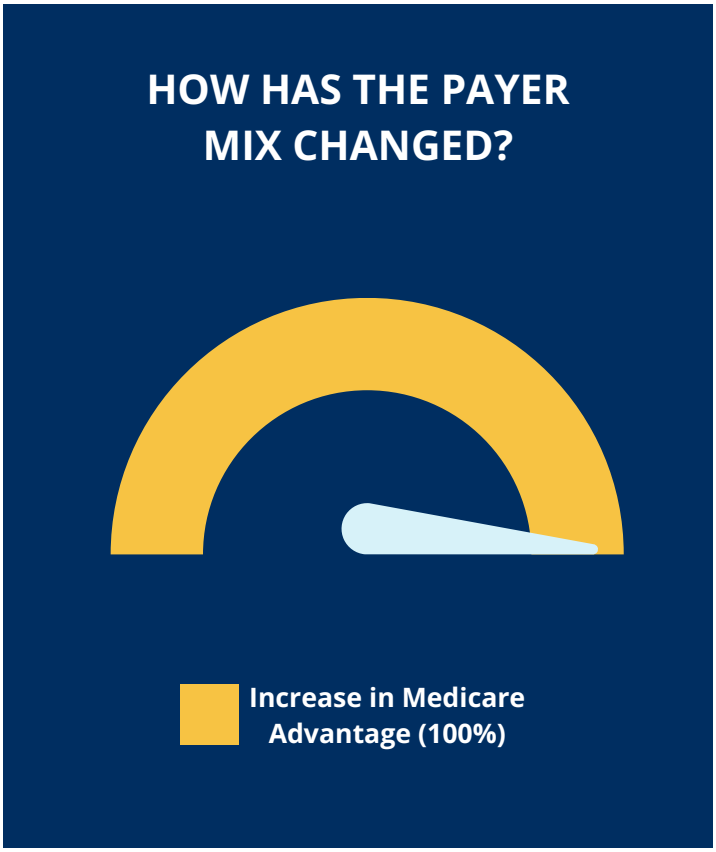

Fig. 8. How has the payer mix changed?

These two survey questions reveal a striking trend: Not only has the payer mix shifted for nearly all rural hospitals in the last five years, but every single respondent noted an increase in Medicare Advantage plans.

This shift highlights a destructive transformation in how hospitals are reimbursed and the financial challenges they face. Traditionally, rural hospitals focused on patient census data to measure operational and financial metrics, but today, the type of insurance a patient carries has become just as important, if not more so. In fact, a larger census might even worsen the financial strain if the majority of those patients have poorly reimbursing plans like Medicare Advantage. See infographic on p. 31 for details.

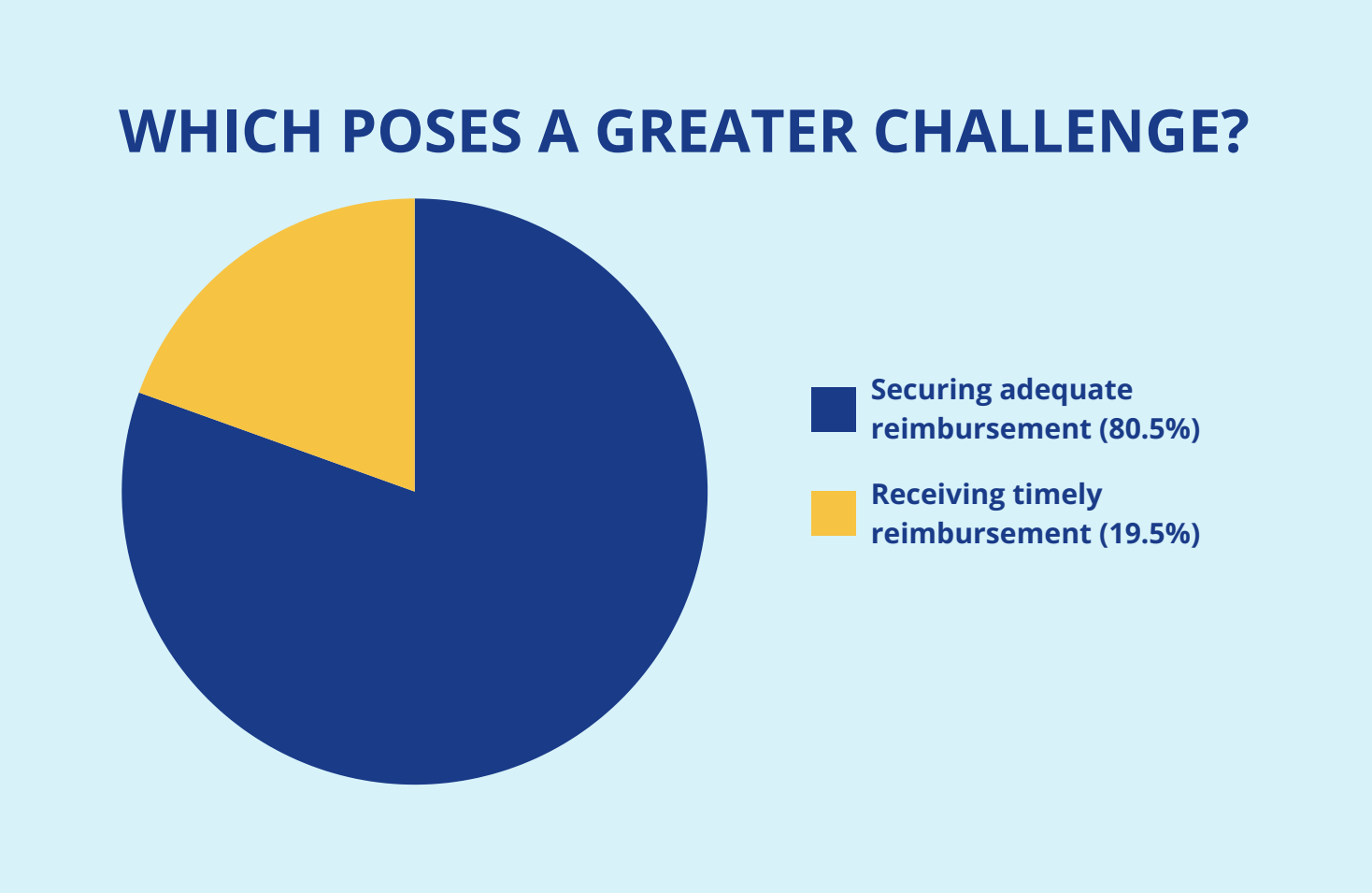

Fig. 9. Which poses a greater challenge?

While securing adequate reimbursement stands out as the top challenge for rural hospitals, many respondents clarified in a phone call that timely reimbursement is almost as great a concern.

They emphasized the unpredictability that comes with the one-two punch of not knowing if they will receive money – the correct, contractually agreed-on reimbursement – and not knowing when it will arrive.

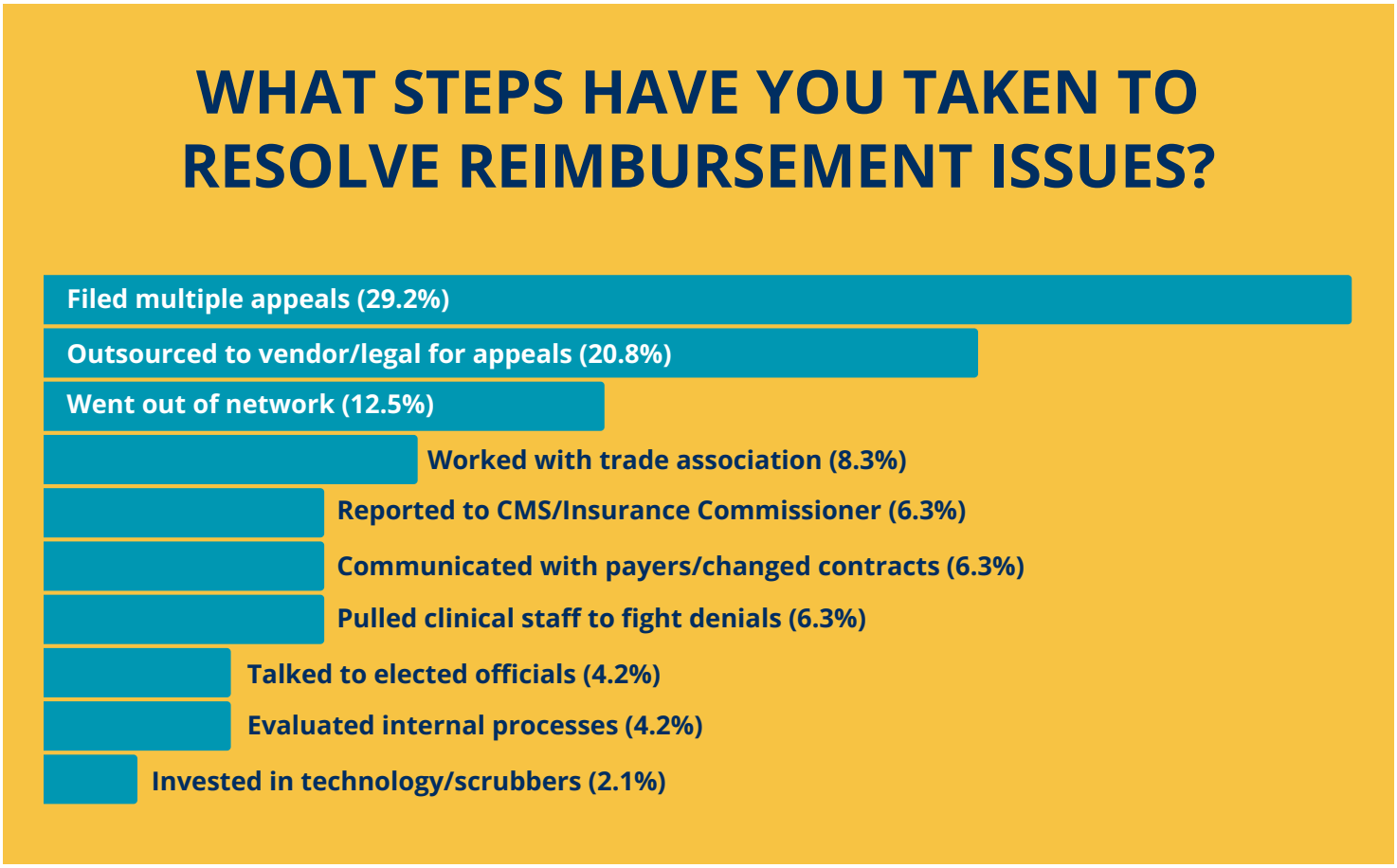

Fig. 10. What steps have you taken to resolve reimbursement issues?

Here, respondents shared the immense resource strain hospitals face when attempting to resolve reimbursement issues, with each step requiring a significant investment of time, staff, and money. In addition to being large and unnecessary administrative burdens, these efforts consistently take resources away from patient care.

Frustrations with reimbursement challenges have led 1 in 8 rural hospitals to take the drastic step of leaving an insurer's network altogether – a move that can hurt local patients enrolled in that corporation's plan.

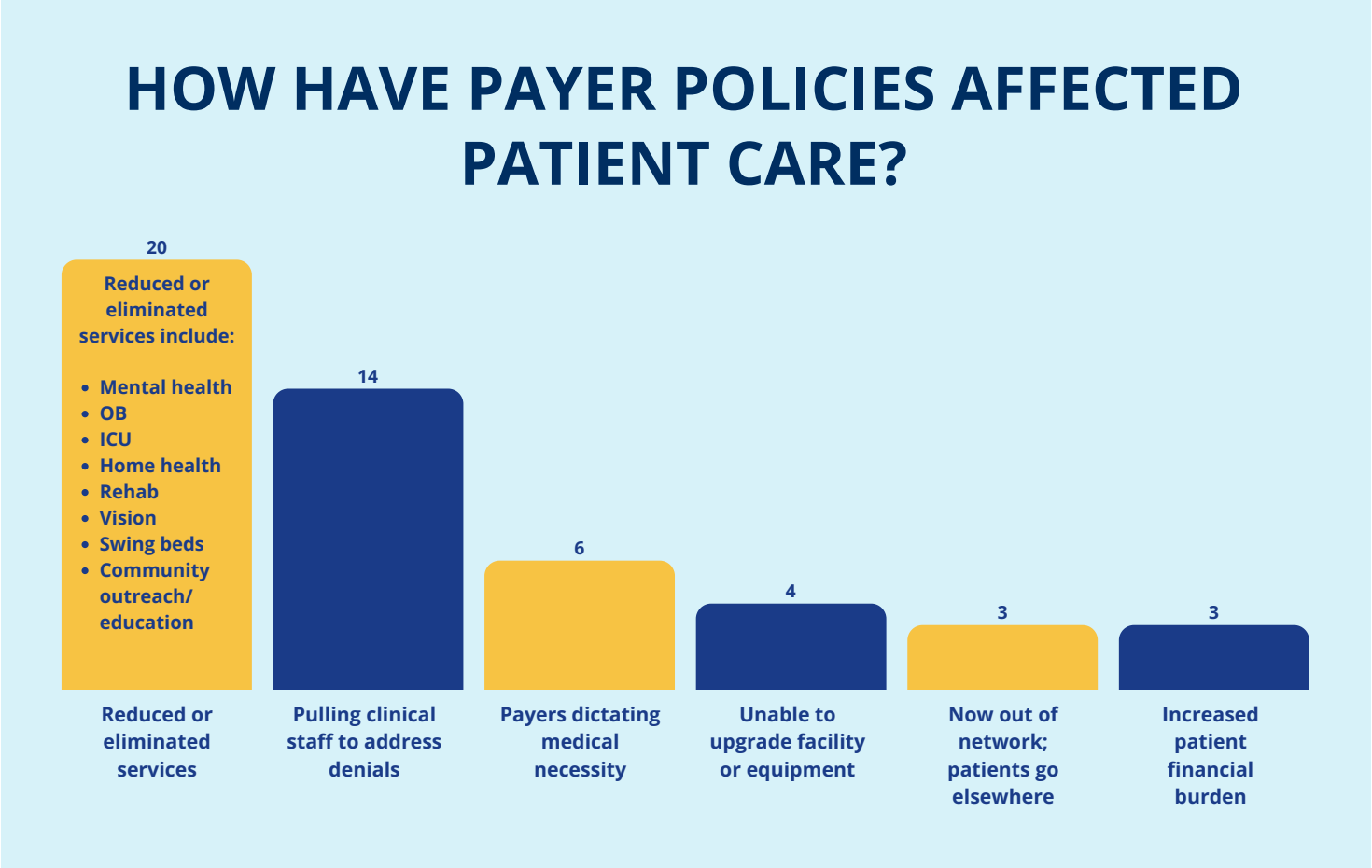

Fig. 11. How have payer policies affected patient care?

Payer policies force rural hospitals to make cuts that harm the communities they serve. The most devastating impact is the reduction or elimination of critical services, including mental health, obstetrics, and rehabilitation. Once these services are closed, patients often have nowhere to go for care that isn't hours away, leaving them to face dangerous delays or forgo treatment altogether.

The loss of swing beds – a flexible resource that allows hospitals to convert acute-care beds for patients needing skilled nursing – is particularly problematic. For many rural areas, swing beds serve as a literal lifeline, enabling hospitals to provide transitional care locally instead of forcing patients to travel long distances to larger facilities.

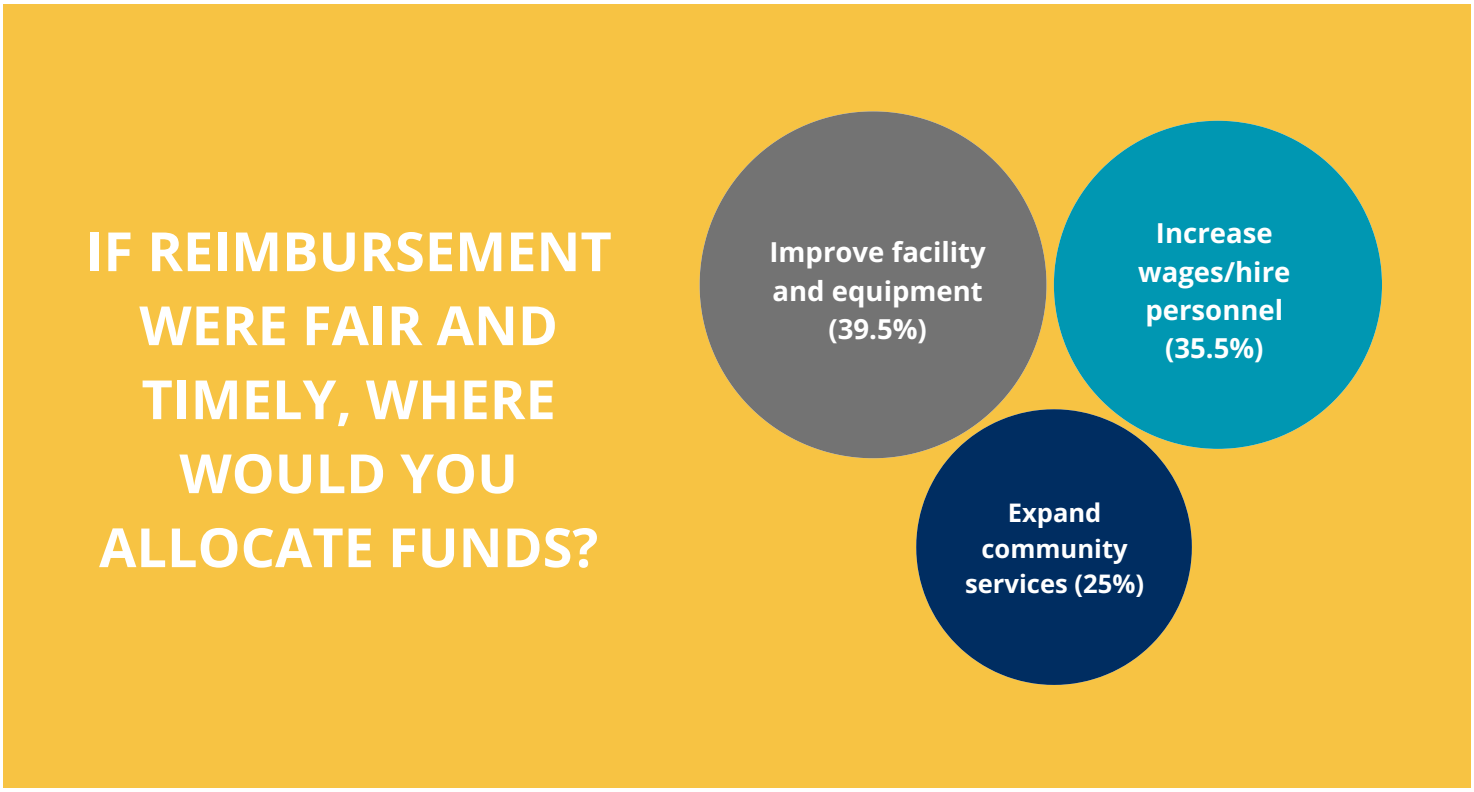

Fig. 12. If reimbursement were fair and timely, where would you allocate funds?

The results here highlight a harsh reality: Our current, profit-centered system actively prevents rural hospitals from performing even the most basic functions they were designed to fulfill.

Maintaining facilities, hiring adequate staff and paying them fairly, and providing essential community services – these are foundational requirements for any hospital. Yet, as a result of corporate insurance practices, rural facilities are struggling with all three.

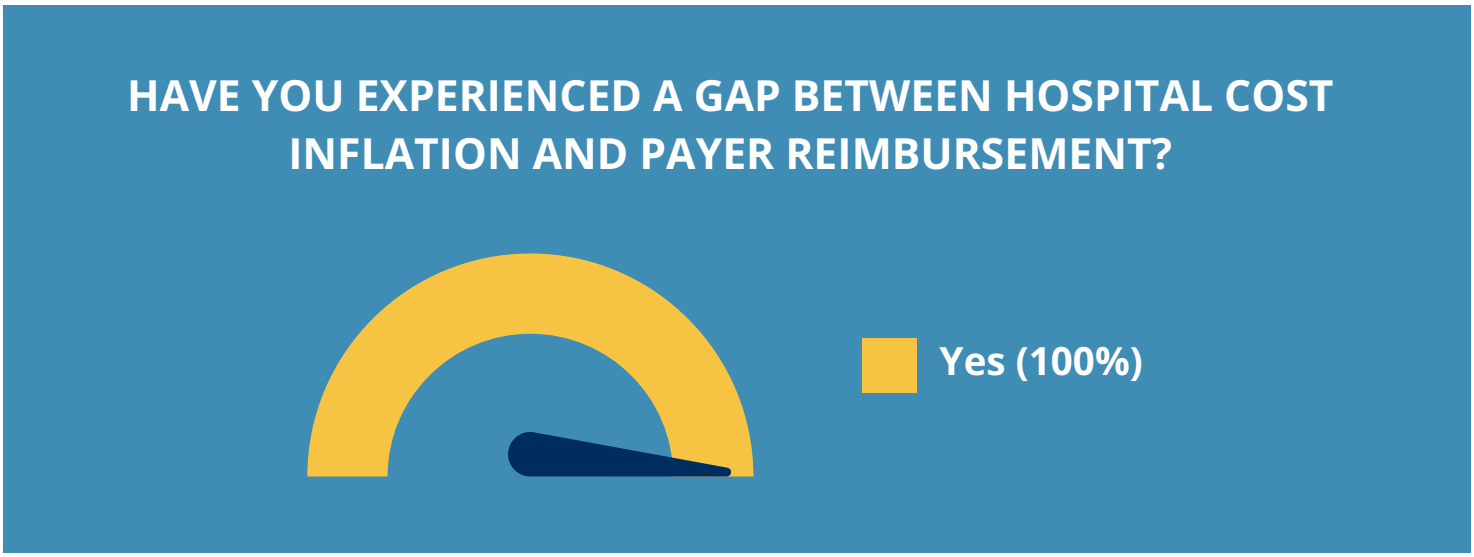

Fig. 13. Have you experienced a gap between hospital cost inflation and payer reimbursement?

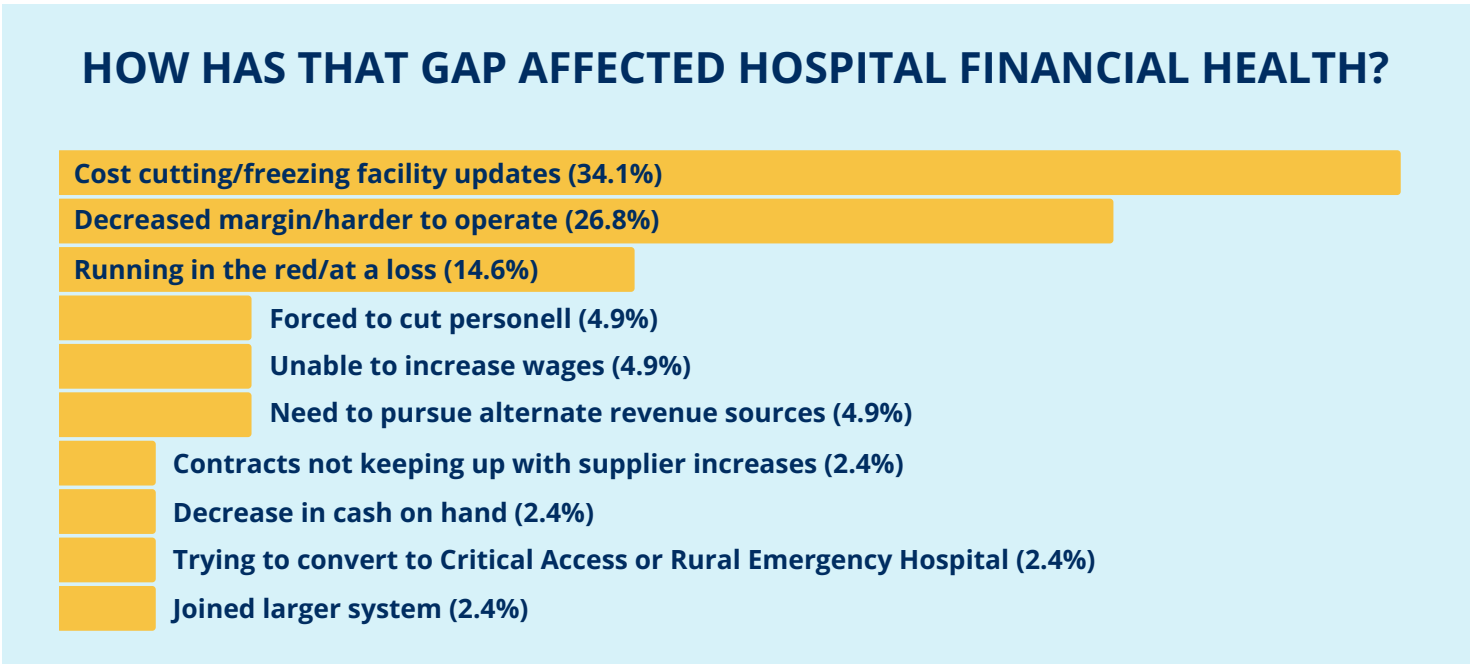

Fig. 14. How has that gap affected hospital financial health?

The gap between hospital cost inflation and payer reimbursement, reported unanimously by respondents, is another difficult financial reality for rural hospitals, forcing them to take drastic measures to remain operational. The top responses – cost cutting, freezing facility upgrades, and operating at reduced margins or at a loss – are desperate stopgap measures, and they are not sustainable.

Over time, we can expect more rural hospitals to consider joining larger health systems to survive. While consolidating in this way may provide relief through improved negotiating power with payers, it often results in a loss of local autonomy and a reduction in services tailored to rural communities.

SURVEY TAKEAWAYS

A rural health care system in crisis, with no end in sight

The results of the survey demonstrate that insurance corporation practices are harming rural hospitals, patient care, and overall community health. Rural hospital leaders told us:

Insurance corporations frequently delay and deny care through unnecessary prior authorizations.

Insurance corporations often drag their feet on reimbursement payments or decline to pay them altogether.

Patients are experiencing ever-growing financial burdens.

Clinical staff are pulled away from care responsibilities to battle with insurance corporations over authorizations and denials of payments for medically necessary treatments.

Critical health services are being cut back or eliminated, including obstetrics, mental health care, rehabilitation services, and disease education.

Insurance reimbursements are not keeping up with inflationary pressures faced by rural hospitals, including the rising costs of supplies, prescriptions, and labor.

Rural hospitals face mounting financial challenges, operating on razor thin margins that threaten their viability and negatively impact patient care.

Medicare Advantage is the central menace facing rural hospitals – and it's only getting worse.

MEDICARE ADVANTAGE:
A GROWING PROBLEM

Our survey confirms what a growing body of evidence has already shown: Deep concerns with the Medicare Advantage program persist even after a damning 2022 report from the U.S. Department of Health and Human Services, which found that Medicare Advantage providers improperly denied prior authorizations 13% of the time, and wrongly denied payment a whopping 18% of the time.[20]

In addition, the American Hospital Association found that care denials soared an average of 55.7% for Medicare Advantage claims between 2022 and 2023.[21] And a 2024 U.S. Senate report concluded that "Medicare Advantage insurers are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities."[22] The skyrocketing denials correspond with growing use of artificial intelligence by insurers, algorithms that can be faulty and can be tuned to decrease approval rates.[23]

The fact that rural hospitals must resort to filing endless appeals, hiring legal teams, and contacting government officials simply to secure fair reimbursement highlights the absurdity of the way Medicare Advantage plans operate. Imagine a teacher having to sue the school board to get paid for teaching a class, or a firefighter needing to negotiate with a corporation before putting out a fire. Yet, for rural hospitals, this has become a necessary and deeply problematic part of their daily work.

20. U.S. Department of Health and Human Services, Office of Inspector General. (2022, April). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260). https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf
21. American Hospital Association. (2024, September 10). *Skyrocketing hospital administrative costs: Burdensome commercial insurer policies are impacting patients and providers*. https://www.aha.org/guidesreports/2024-09-10-skyrocketing-hospital-administrative-costs-burdensome-commercial-insurer-policies-are-impacting
22. U.S. Senate Committee on Homeland Security and Governmental Affairs. (2024, October 17). *Majority staff report on Medicare Advantage*. https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
23. Ross, C., & Herman, B. (2023, March 13). *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*. STAT. https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/

Nonetheless, Medicare Advantage is growing. Since Congress expanded the program in 2003, enrollment has increased steadily. Today, 32.8 million people are enrolled in a Medicare Advantage plan, accounting for more than half of the eligible Medicare population.[24]

As noted earlier, much of the growth is a result of misleading Medicare Advantage ads that confuse seniors with promises of benefits while concealing the high costs and coverage limitations these plans impose. A 2023 study by health policy organization KFF found that "Medicare open enrollment TV ads are dominated by Medicare Advantage plans featuring celebrities, active and fit seniors, and promises of savings and extra benefits without fundamental plan information."[25]

Seniors report being enrolled in certain plans without realizing it, often believing they were signing up for a supplemental plan to enhance traditional Medicare, when in fact, they were enrolled in a replacement Medicare Advantage plan.[26]

WHY HAVEN'T POLICYMAKERS ACTED?

Despite mounting evidence and consistent outcry from rural healthcare leaders and other critics, the Medicare Advantage program continues to grow. Misaligned incentives, lobbying power, and corporate profiteering have enabled insurance companies to do largely as they please.

The question remains: How much longer will rural hospitals, patients, and communities be forced to pay the price as insurance profits continue to increase?

24. Freed, M., Biniek, J.F., Damico, A., & Neuman, T. (2024, August 8). *Medicare Advantage in 2024: Enrollment update and key trends*. KFF. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/
25. KFF. (2023, October 18). *KFF research shows that Medicare open enrollment TV ads are dominated by Medicare Advantage plans featuring celebrities, active and fit seniors, and promises of savings and extra benefits without fundamental plan information*. https://www.kff.org/medicare/press-release/kff-research-shows-that-medicare-open-enrollment-tv-ads-are-dominated-by-medicare-advantage-plans-featuring-celebrities-active-and-fit-seniors-and-promises-of-savings-and-extra-benefits-without-fund/
26. Abelson, R., & Sanger-Katz, M. (2022, November 3). Private Medicare plans often market misleading advantages. *The New York Times*. https://www.nytimes.com/2022/11/03/upshot/private-medicare-misleading-marketing.html

Why Rural Hospitals Are Struggling Under Medicare Advantage

TRADITIONAL MEDICARE	VS	MEDICARE ADVANTAGE
Operates under standard federal reimbursement rates, ensuring consistency and fairness across all hospitals	**Contracts and Reimbursements**	Reimbursement rates are largely dictated by insurance corporations and may be significantly lower
Reliably covers medically necessary services, without the need for complex authorizations	**Authorizations and Claim Denials**	Requires cumbersome approvals for standard care and issues frequent denials, leading to major staff and administrative burdens
Provides timely, predictable payments, allowing for streamlined budgeting and forecasting	**Payment Timeliness**	When MA plans do pay, reimbursement is notoriously delayed, leading to cash flow crises and service disruption
Provides reimbursement for patients' unpaid Medicare copays and deductibles. Also provides 101% reimbursement of allowable costs for many rural hospitals	**Federal Subsidies**	Does not honor either of these subsidies, resulting in significant, critical cash loss
Supports stability and access to care for rural communities; thriving hospitals, healthy population	**Overall Impacts**	Results in cuts to essential services, department elimination, staff burnout, moral injury, and hospital closure

WRITE-OFF WARRIOR

The Moral Injury Insurance Corporations Inflict on Clinicians – and Rural Communities

Authorization denials and delays violate clinicians' code of ethics, hurting performance and staffing levels

One lesser-known way health insurance corporations harm the heartland has to do with the moral injury they inflict on doctors and other clinicians.

"Moral injury" refers to the profound sense that you've betrayed your ethical code.

For health care professionals, that ethical code typically includes doing no harm, upholding human dignity, and providing all patients with access to care.

Over the past decade in particular, clinicians have had their morals challenged and violated by health insurance corporations that routinely deny or delay treatments.

Danny Everson, radiology manager at Miller County Hospital in Colquitt, Georgia, says that insurance payers frequently decline to approve tests that clinicians believe are necessary for patients.

"Insurances are getting to the point of deciding who lives and who dies," he says.

Danny isn't alone in viewing insurance corporations as causing clinicians ethical turmoil. A 2021 survey by the American Medical Association found that 88% of physicians said having to apply to insurers for approval to treat patients led to harms, including avoidable hospitalizations.[27]

Moral injury among health care workers has been linked to guilt, shame, and anger, and can lead to depression, post-traumatic stress disorder, and suicidality.[28, 29]

Carol Paris, MD, past president of the advocacy group Physicians for a National Health Program, says recent attention to "burnout" among healthcare workers distracts from the real problem doctors face: the moral damage done by a system focused on maximizing insurance company earnings.

> **We need freedom from the shackles of the corporate health insurance industry.**

"Doctors don't need yoga and meditation," Paris says. "We need freedom from the shackles of a corporate health insurance industry that constrains us from giving patients the treatment we took an oath to provide."

Another effect of moral injury is fewer health care professionals in rural America. Doctors today are leaving the profession because of the injustices they witness in a system dominated by insurance corporations.[30, 31]

Already, two-thirds of rural areas suffer from a shortage of primary care physicians. Doctors quitting to preserve their sense of integrity adds to the harm insurance corporations are doing to rural communities.[32]

Doctors are leaving the profession because of the injustices they witness in a system dominated by insurance corporations.

27. American Medical Association. (2024). *2023 Prior authorization physician survey*. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
28. The Commonwealth Fund. (2023, August 17). *Responding to burnout and moral injury among clinicians*. https://www.commonwealthfund.org/publications/2023/aug/responding-burnout-and-moral-injury-among-clinicians
29. Williamson, V., Murphy, D., Phelps, A., Forbes, D., & Greenberg, N. (2021, June). Moral injury: The effect on mental health and implications for treatment. *The Lancet Psychiatry*, 8(6), 453–455. https://doi.org/10.1016/S2215-0366(21)00113-9
30. Rosen, A., Cahill, J. M., & Dugdale, L. S. (2022, August 15). Moral injury in health care: Identification and repair in the COVID-19 era. *Journal of General Internal Medicine*, 37(14), 3739–3743. https://pmc.ncbi.nlm.nih.gov/articles/PMC9377663/
31. Davis, W. (2023, June 15). Doctors' moral crises: The mental health toll of impossible choices. *The New York Times Magazine*. https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html
32. Empinado, H. (2023, September 25). *Treating rural America: The last doctor in town*. STAT. *https://www.statnews.com/2023/09/25/rural-health-doctor-shortage-physicians/*

INSURANCE INDUSTRY PROFITS AND LOBBYING

Medicare Advantage: The greatest corporate steal in American history

Consider the top six health insurance companies in the United States today. If you go back to 2003, only UnitedHealthcare posted profits of $1 billion or more. In 2023, all six posted profits of more than $1 billion. UnitedHealthcare alone enjoyed a profit of more than $22 billion in 2023. [33]

Insurers have transformed taxpayer funding into a vast engine of corporate growth and profitability.

What's more, none of the six ranked in the top 50 of the Fortune 500 list in 2003. Now, all six do – and UnitedHealthcare and Aetna/CVS are in the top 10.

As noted, this dramatic growth can be traced back to the 2003 Medicare Modernization Act. That law expanded the Medicare Advantage program and funneled billions of taxpayer dollars into private insurers, allowing them to expand their influence and profits exponentially.

In essence, insurers have transformed taxpayer funding into a vast engine of corporate growth and profitability.

Not all of the profits of the six largest insurance companies come from Medicare Advantage. But all take advantage of it. And the insurer with the biggest profit – UnitedHealthcare – has the biggest share of Medicare Advantage enrollees. United's portion of all Medicare Advantage enrollment has climbed from 20 percent in 2010 to 29 percent in 2024.[34]

33. Figures compiled from SEC filings accessed through the EDGAR database. See Appendix A.

34. Freed, M., Biniek, J. F., Damico, A., & Neuman, T. (2024, August 8). *Medicare Advantage in 2024: Enrollment update and key trends*. KFF. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

How does the health insurance industry's growth stack up with other US companies?

Put simply, you will be hard-pressed to find an industry or group of companies that has done better in 20 years than this group of corporations.

It's not a stretch to call the exploitation of Medicare Advantage by insurance corporations the greatest steal in American history – a heist that has victimized US taxpayers, rural hospitals, and heartland communities.

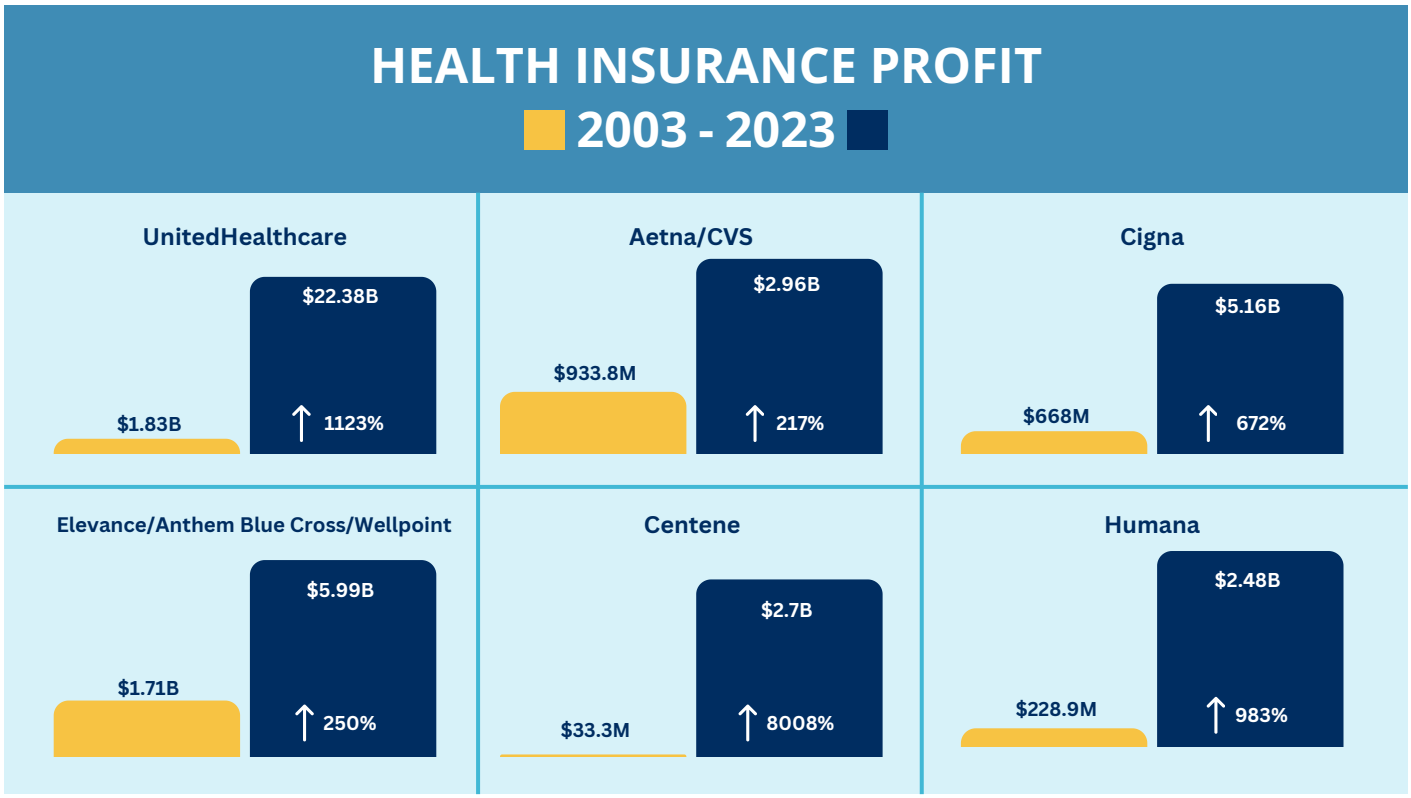

Fig. 15. Increase in payer profits from 2003 (passage of Medicare Modernization Act) to 2023. Figures compiled from SEC filings accessed through the EDGAR database. See Appendix A.

It might make sense for Medicare Advantage to enjoy Congressional support if it were achieving its original goals: Give consumers greater choices, improve care, and save taxpayers money.

But as we've seen, the private corporations pitching Medicare Advantage programs often mislead Americans as they make choices about their health care.

Nor does the evidence show Medicare Advantage is improving care or reducing costs. In fact, research finds that Medicare Advantage costs taxpayers more than traditional Medicare. (See sidebar, "Explanation of Non-Benefits" on p. 16.)

Why, then, would lawmakers continue to support the program? It comes down to an old adage: Money talks.

The six largest health insurers have more than quintupled their spending on lobbying efforts, from $9.3 million in 2003 to over $51 million in 2023.[35] And this $51 million does not even account for money spent by the health insurance industry on political campaigns.

Investing $51 million and more into lobbying is actually a small price for corporations to pay to keep their golden goose – Medicare Advantage – healthy.

And the logic of exploiting the Medicare Advantage program to inflate earnings makes sense for for-profit companies: They ultimately serve shareholders, not patients or communities.

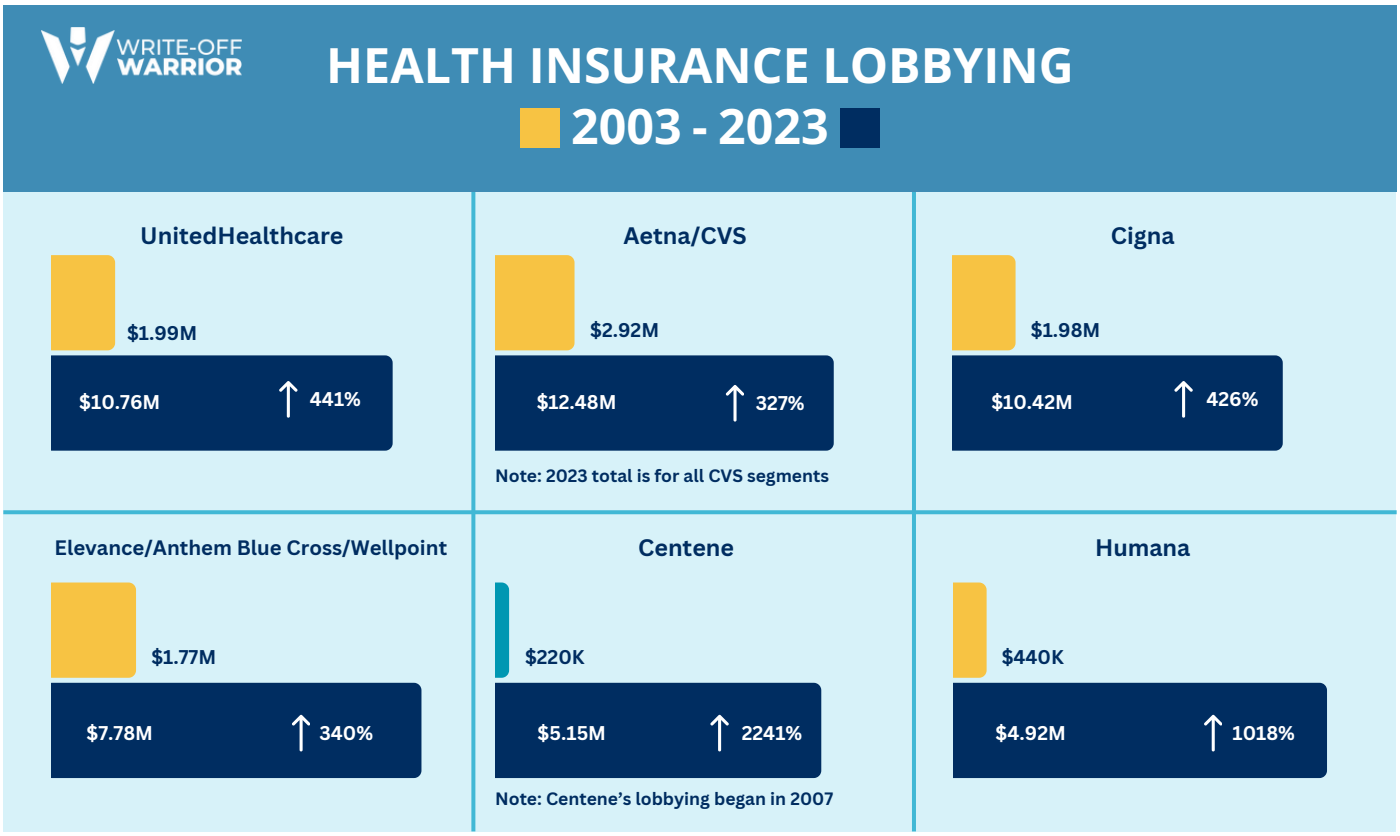

Fig. 16. Health insurance lobbying, 2003 and 2023. The massive increase in lobbying dollars is directly tied to the massive increase in payer profits. Figures compiled from OpenSecrets. See Appendix B.

Protected by their lobbying power, private insurers have turned taxpayer-funded programs into tools for corporate gain, while rural hospitals and their patients continue to suffer.

35. Figures compiled from OpenSecrets. See Appendix B.

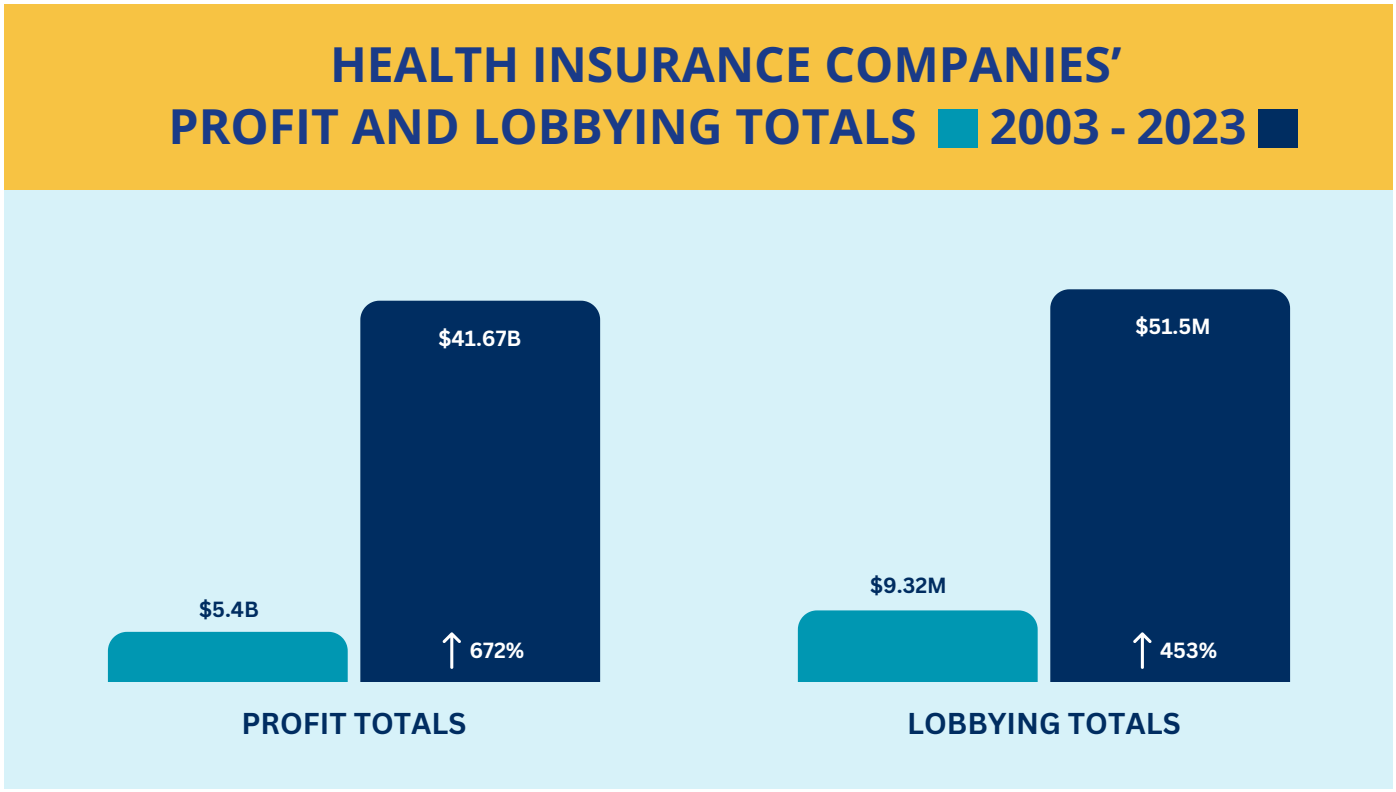

Fig. 17. Big six insurers' profit and lobbying totals, 2003 and 2023. See Appendix A and B for detailed breakdowns.

HEALTH INSURANCE COMPANIES' FORTUNE 500 RANKINGS 2003 - 2024

Insurance Name	2003 Fortune 500 List	2024 Fortune 500 List
UnitedHealthcare	63	4
Aetna/CVS	88/68	6
Cigna	87	16
Elevance Health/Anthem Blue Cross/Wellpoint	146/103/381	20
Centene	NA	22
Humana	169	38

Table 1. Health insurance companies' Fortune 500 rankings, 2003 – 2024

FIGHTING BACK AGAINST MODERN-DAY DRACULAS

Rural hospital CEOs and their allies must win over the public, parry insurance companies' tactics, and inform patients of their choices

In practice, Medicare Advantage has created a monster. Private insurance payers have incentives to say no to treatments and slow-walk reimbursements.

Then they can hide in the shadows, as strapped rural hospitals try to collect from patients – many of whom can't afford big medical deductibles pushed by their insurance plan and find insurance rules confusing.

But rural hospital leaders and their allies aren't powerless.

What we need to do is fight the monsters and dismantle the system that created them.

In the original Dracula story, it took a group of brave people banding together to destroy the vampires. It will take the same for us to rescue rural hospitals and help patients.

> *The most important thing rural hospital leaders can do is tell their story.*

In particular, we need to fight these modern-day Draculas on three levels: Persuading the public, resisting insurance company attacks, and providing patients with the information they need to battle these predators.

Persuading the public

The most important thing rural hospital leaders can do is tell their story. Talk to as many people, media outlets, and influencers as possible, through channels such as op-eds and social media posts. Local news stations and radio stations are always looking for compelling stories, and it's fairly easy to get airtime. Reveal what initiatives you have that are being hurt by insurance corporation policies like excessive authorizations and denials.

Similarly, tell patient stories via the same outlets. With proper permission or in anonymous fashion, share the suffering of patients caused by corporate greed. Human stories move people.

If multiple stakeholders collectively protest our broken system of corporatized medicine, the message may carry more weight.

Engage a broader coalition of rural hospital leaders, healthcare advocates, and physician, nursing, and patient organizations to amplify the call for reform.

Business leaders can also join the fight, as they're directly affected by rising premiums and deductibles. Increasing health care costs and medical debt are making Americans sicker and poorer, which hurts both employee productivity and consumer spending.[36, 37]

If multiple stakeholders collectively protest our broken system of corporatized medicine, the message may carry more weight with policymakers.

Finally, meet directly with those policymakers. Seek to share your story and perspective with state and federal government officials and elected leaders. You may get a hearing. And you may make a difference in changing the monstrous system harming your community and rural America overall.

For several specific policy recommendations to support rural hospitals and hold insurers accountable, see page 43.

36. Smith, R. A. (2024, October 14). Health costs and flat raises are set to squeeze paychecks. *The Wall Street Journal.* https://www.wsj.com/lifestyle/careers/health-costs-and-flat-raises-are-set-to-squeeze-paychecks-34fb94a4

37. Commonwealth Fund. (2023, October 26). *Paying for it: How health care costs and medical debt are making Americans sicker and poorer.* https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey

Resisting insurance company attacks

Rural hospitals also can fight back against abusive insurance companies directly. It may seem like an uphill battle when insurers delay routine procedures or refuse to pay for services that doctors deem medically necessary.

In fact, Mark Burket, CEO of Platte Health Center Avera in South Dakota, sees a calculated intention behind the denials and delays: Pressuring rural hospitals to write-off costs.

"I think it's part of the strategy of these companies to basically tire the industry out," he says. "Or have hospitals decide that fighting the denials isn't worth it, especially on lower dollar claims."

But you can beat them at their own game.

There are now resources for rural hospital leaders to resist unfair practices. For example, a number of advisory firms can provide template letters for appealing insurance company decisions.

Hospital leaders can file grievances with the Centers for Medicare & Medicaid Services.

Many of these denials are based on AI algorithms that automate asking for additional – often unnecessary – information.[38] It's possible to overturn them with mininum effort.

For insurance claims that have not been paid or have been denied, outsourcing revenue cycle operations also can reduce the burden on rural hospitals. Outsourced partners operate on different payment models including a contingency fee model, meaning that the partner takes a percentage of successful reimbursements only.

There are pros and cons to working with an outside firm. Consider factors including the technology capabilities of potential partners, staffing costs, and overall return on investment.

38. Williams, J. (2024, March 28). Battle of the bots: As payers use AI to drive denials higher, providers fight back. *Healthcare Financial Management Association*. https://www.hfma.org/revenue-cycle/denials-management/health-systems-start-to-fight-back-against-ai-powered-robots-driving-denial-rates-higher/

Hospital leaders can also file grievances and complaints on Medicare Advantage plans with the Centers for Medicare & Medicaid Services – the federal agency that oversees Medicaid programs. Hospital executives can file other complaints about insurers with their state Insurance Commissioners.

Threatening to go out of network can sometimes force payers to change. But this approach comes with significant risks.

As a last resort, hospitals may consider cutting ties with insurers that refuse to negotiate fair contracts or operate in good faith. This is referred to as "going out of network."

Leaving an insurer's network of providers – or threatening to do so – can sometimes force payers to change. They may be persuaded to pay higher rates, submit payments on a more timely basis, reduce pre-authorization requirements, and lower denial rates.

But this approach comes with significant risks – patients covered by those insurers may face steep out-of-pocket costs, and fewer may seek care locally. This is a decision that should be made carefully. Providers may want to consult with organizations such as local employers, community groups, the American Hospital Association, and state rural medical associations.

Supplying patients with information

Patients today face a flood of misleading information from insurance corporations. This includes Medicare Advantage propaganda, as well as messaging that obscures the true impact of "cost-sharing" policies. These policies – better called "cost-shoving" – push financial burdens onto patients through high deductibles and copays, leaving rural hospitals to collect fees from frustrated patients who may not fully understand their options.

Rural hospitals can counteract this by equipping patients with the tools and knowledge to make informed decisions.

This begins with empathetic communication during billing discussions. Staff trained in science-backed techniques and equipped with clear, compassionate scripts can defuse tension, foster trust, and make it clear that insurance corporations are the real villains, not the hospital.

Yes, there are rules that prevent providers from advocating for or against particular insurance payers.

But hospital personnel can refer patients to state insurance departments or programs like SHIP (State Health Insurance Assistance Programs) for guidance on insurance decisions. SHIP agencies provide free and unbiased information to educate beneficiaries on health and drug plan options, without promoting or endorsing specific insurance plans.

Providing and explaining resources upfront can prevent confusion and ensure patients access the care they need.

You can also leverage scripts for legally explaining the benefits, responsibilities, and consequences of different insurance plans. These include the little-known features of Medicare Advantage plans, such as treatment prior authorizations that can delay care, as well as provider network rules that can lead to expensive co-pays.

Additionally, rural hospitals can offer financial assistance and Medicaid eligibility screenings for uninsured patients.

Explaining these resources upfront can prevent confusion and ensure patients access the care they need without unnecessary stress.

CMS.gov
Centers for Medicare & Medicaid Services

File an MA grievance

SHIP
State Health Insurance Assistance Program

Find your local SHIP

POLICY RECOMMENDATIONS

Holding insurers accountable is critical to sustaining rural healthcare

The challenges rural hospitals face cannot be solved without systemic change. These three policy recommendations target the core problem – unregulated insurance practices – that stands in the way of a more transparent and sustainable healthcare system.

Recent public attention to health insurance companies suggests popular sentiment could drive meaningful reform. Now is the time to channel this momentum into decisive action.

Demand Transparency and Accountability from Insurance Corporations

Hospitals and other medical providers face intense government regulation and are held accountable in other ways, such as malpractice claims.

By contrast, insurance corporations operate with far less oversight, creating a playing field where rural hospitals and patients are at a severe disadvantage.

Among the federal guidelines needed are rules requiring insurers to provide rural communities with adequate in-network access to specialists and mental health services.

There must be meaningful, consistent repercussions and financial consequences when insurers fail to meet basic standards.

There has been some progress. Last year, the federal government finalized a rule that requires health insurers – including Medicare Advantage plans – to meet stricter deadlines when deciding on prior authorization for medical treatments. In 2026, insurers will have to approve or deny urgent prior authorizations within 72 hours, and will have to provide a specific reason for denials.

Just as hospitals and medical providers face significant penalties for non-compliance with regulations, so should insurance corporations.

The new rule also requires payers to publish prior authorization metrics on their websites, including which services require prior authorizations, the number of denials and approvals, and prior authorization denials overturned after appeal.[39]

But there are concerns the new rule will not effectively penalize corporations for meeting these deadlines and requirements. And in general, more regulation of the insurance industry is needed. The American Hospital Association and other groups are advocating for more robust measures to hold commercial health insurers accountable for their actions.

One concept gaining momentum is the payer "scorecard." This is a standard, comprehensive assessment of how each insurance payer is performing on a range of metrics, such as payment rates, claims processing efficiency, payment timeliness, denial rates, utilization oversight, and overall collaboration. The Healthcare Financial Management Association, an industry group for healthcare finance professionals, has been developing such a scorecard.[40]

39. Pifer, R. (2024, January 17). *CMS finalizes rule tightening prior authorization turnaround for insurers*. Healthcare Dive. https://www.healthcaredive.com/news/cms-final-prior-authorization-rule-payer-deadline/704721/

40. Reese, E. C. (2023, November 22). *Payer scorecards hold promise for promoting an enhanced payer-provider equilibrium*. Healthcare Financial Management Association. https://www.hfma.org/payment-reimbursement-and-managed-care/payer-scorecards-hold-promise-for-promoting-an-enhanced-payer-provider-equilibrium/

But tracking payer performance and behavior can go only so far. Just as hospitals and medical providers face significant penalties for non-compliance with regulations, so should insurance corporations. Previous health care regulations governing insurers haven't always been enforced. There must be meaningful, consistent repercussions and financial consequences when these payers fail to meet basic standards.

Process Medicare Advantage Claims Through an Independent Organization

One specific reform that would improve health care in rural America and beyond is creating an independent organization to make fair, efficient judgements about care and coverage. Congress should establish a Medicare Advantage Medicare Administrative Contractor (MAMAC).

This organization would manage key administrative services across all Medicare Advantage plans. It would handle precertification decisions, claims reviews, and appeals rulings using standardized processes and procedures.

A MAMAC would ensure consistency, reduce burdens on rural hospitals, and close loopholes that allow Medicare Advantage plans to flout existing rules.

A MAMAC would enforce existing rules and regulations more effectively by:

- ✓ Eliminating insurers' ability to unfairly deny or delay care by enforcing the requirement to cover medically necessary services.
- ✓ Mandating accurate reporting on denials, approvals, and payment timelines, which would expose violations and patterns of non-compliance that currently go unchecked.
- ✓ Triggering automatic financial penalties for plans failing to comply with existing Medicare Advantage rules, creating real consequences for bad actors.
- ✓ Reducing appeals burdens by applying clear, consistent standards across all plans, so that hospitals no longer shoulder the administrative costs of constant appeals.

Under this approach, plans would still pay providers according to their negotiated contracts. But oversight by a neutral, centralized third-party would prevent inappropriate denials, excessive delays, and administrative hurdles.

Crack Down on Deceptive Health Insurance Advertising

Additional regulation and enforcement also are needed to address misleading marketing by health insurance corporations. The insurance industry's advertising tactics resemble those of Big Tobacco – deceptive, manipulative, and designed to confuse consumers. These practices are particularly harmful during open enrollment periods, when seniors are inundated with Medicare Advantage advertisements featuring celebrities and vague, unrealistic guarantees.

Insurers often provide coverage details, denied claims information, and out-of-pocket cost formulas in ways that are opaque, inconsistent, and difficult for both patients and providers to navigate.

To protect consumers, regulations must prohibit advertising that misrepresents plan benefits. Instead, insurers must be required to describe Medicare Advantage plans and other products in clear, straightforward language.

Addressing deceptive health insurance ads is especially important in rural communities, where patients are disproportionately affected by "ghost networks" of nonexistent or inaccessible providers.

The Federal Trade Commission says it is "monitoring" the insurance industry "for potentially deceptive or unfair acts or practices related to healthcare insurance and healthcare-related products." [41] But more scrutiny is needed.

Cracking down on deceptive health insurance ads is especially important in rural communities, where patients are disproportionately affected by "ghost networks" of nonexistent or inaccessible providers.

Additionally, insurance agents and brokers must be held to high standards through regulations that prevent them from steering patients into plans that do not align with their healthcare needs. Strong oversight, enforced transparency, and rigorous accountability will make it far more likely that recommended insurance plans serve the best interests of patients, rather than exploiting their trust.

41. Ensor, J. S. (2024, December 10). *Selling health insurance plans or healthcare-related products? Take your marketing and advertising for its annual checkup*. Federal Trade Commission. https://www.ftc.gov/business-guidance/blog/2024/12/selling-health-insurance-plans-or-healthcare-related-products-take-your-marketing-advertising-its

Anger at Insurance Executives

A CEO's murder illuminates widespread fury at insurance industry leaders

Brian Thompson, the CEO of UnitedHealthcare (the health benefits business of parent company UnitedHealth Group), was fatally shot on December 4, 2024.

Reports said the words "delay," "deny" and "depose" were found on bullet casings at the scene – suggesting anger about health insurance industry tactics to avoid paying for care. And many on social media framed the alleged killer as a folk hero.

It's tempting to scapegoat insurance CEOs for problems with the US healthcare system.

But these corporate leaders are just doing what many CEOs do: Make a profit regardless of the collateral damage.

Unfortunately, in healthcare, collateral damage can take the form of a family member suffering, or a patient being forced to leave their hometown because needed care isn't available.

The corporatization of our healthcare system is not the result of one individual, but rather the culmination of decades of failed policies, lobbying efforts, and the financialization of care by insurance corporations. Our mission is to dismantle this broken system and prioritize improving health outcomes for all patients and the dedicated medical providers who serve them.

We unequivocally condemn violence as both unacceptable and counterproductive. It does not bring about the meaningful change needed to reform healthcare. Our hearts go out to Brian's family for the suffering they have endured.

While the comments circulating on social media are deeply concerning, they underscore a troubling reality: Many people feel abandoned and hopeless within the current system.

This only strengthens our resolve to advocate for meaningful change through constructive, nonviolent action.

While the comments circulating on social media are deeply concerning, they underscore a troubling reality.

CONCLUSION

Our survey documented the way rural hospitals and communities are under attack, preyed on by vampiric health insurance corporations.

And this report is part of a growing recognition that our system of rural health care is ailing.

"The odds are stacked against rural hospital survivability," says Jimmy Lewis, CEO of HomeTown Health, a network of rural healthcare organizations that advocates on behalf of members as reimbursement rates decline and rules change. "The increasingly difficult negotiation and communication with insurance companies and the expansion of red tape and processes related to authorizations and appeals over denials causes a heavy burden with direct impacts on the bottom line."

Health insurance corporations have proven they care far more about profits than patients, and many are dying at the altar of their greed.

Based on our survey and interviews with rural hospital leaders, various reforms are critically needed.

These include additional regulation and oversight of the corporations at the center of our healthcare system.

New policies must ensure greater transparency, faster approval decisions, and requirements forcing Medicare Advantage providers to function more like traditional Medicare when it comes to approval processes and payments.

Some stakeholders go further.

They argue for requiring Medicare Advantage payers to be non-profit entities – believing this shift would reduce the incentive to extract precious resources from hospitals and communities to enrich corporate shareholders.

Among those calling for change is Dr. Ed Weisbart, national board secretary and Missouri chapter chair of Physicians for a National Health Program, a non-profit advocacy organization.

"Today, four people – Sir Andrew Witty, Jim Rechtin, Kim Keck, and David Joyner – are the CEOs of the four insurance companies (UnitedHealthcare, Humana, BCBS, and CVSHealth) that control 73% of the Medicare 'Advantage' industry, and they're growing larger every day," Weisbart says.

"These four people couldn't care less about rural health other than as a market to increase their personal and organizational wealth. And many of us are dying at the altar of their greed."

It's time to stop the dying.

It's time to stop the profiteering by a handful of giant companies that are harming rural Americans, driving frustrated doctors out of the profession, and threatening our national wellbeing.

Time to stop the profiteering by a handful of giant corporations that are harming rural Americans, driving frustrated doctors out of the profession, and threatening our national wellbeing and ability to respond to the next pandemic.

Time to reject the reflexive cries of "socialized medicine!" by the insurance industry whenever advocates challenge the status quo.

Time to remedy America's "corporatized medicine" – an approach that prioritizes profits and shareholder returns over patients and positive health outcomes.

It's time to destroy this monstrous system before it bleeds even more rural hospitals and communities to death.

Appendix A: Big Six Insurance Profits, 2003 and 2023

This report uses "Net earnings attributable to common shareholders" as the metric for profit, as it is the standard measure of profitability in financial analysis. This metric is widely accepted because it represents the amount of earnings available to shareholders after all expenses, taxes, and adjustments for non-controlling interests. Use of this metric avoids distortions that might arise from non-operating items or extraordinary adjustments, and provides consistency and comparability across companies and over time.

UnitedHealthcare

2003: U.S. Securities and Exchange Commission. (2004). UnitedHealth Group Form 10-K for fiscal year ended December 31, 2003, p. 13.
https://www.sec.gov/Archives/edgar/data/731766/000095013404003522/c82635exv13.htm

2023: U.S. Securities and Exchange Commission. (2024). UnitedHealth Group Form 10-K for fiscal year ended December 31, 2023, p. 26.
https://www.sec.gov/Archives/edgar/data/731766/000073176624000081/unh-20231231.htm

Aetna/CVS

2003: U.S. Securities and Exchange Commission. (2004). Aetna Inc. Form 10-K for fiscal year ended December 31, 2003, p. 27.
https://www.sec.gov/Archives/edgar/data/1122304/000095012304002526/y94281e10vk.htm

2023: U.S. Securities and Exchange Commission. (2024). CVS Health Corporation Form 10-K for fiscal year ended December 31, 2023.
https://www.sec.gov/Archives/edgar/data/64803/000006480324000007/cvs-20231231.htm

Calculation Note: The estimated net profit for CVS Health's Health Care Benefits segment in 2023 was calculated using data from the company's 10-K filing. The filing did not include a line item for net earnings attributable to common shareholders specific to the Health Care Benefits segment. However, it provided:

Operating Income for the Health Care Benefits segment: $3.949 billion (p. 84).
Effective Tax Rate for CVS Health as a whole: 25.1% (p. 174).

After applying the effective tax rate, the estimated net profit for the Health Care Benefits segment in 2023 is approximately $2.96 billion. This figure represents the best possible approximation given the available data. While it does not account for interest expenses or non-operating items, the omission of these figures is unlikely to significantly affect the accuracy of the estimate because such items typically represent a small proportion of total segment income and are not expected to materially impact the segment's overall profitability.

Cigna

2003: U.S. Securities and Exchange Commission. (2004). Cigna Corporation Form 10-K for fiscal year ended December 31, 2003, p. FS-6.
https://www.sec.gov/Archives/edgar/data/701221/000095015904000243/cigna10-k2003.htm

2023: U.S. Securities and Exchange Commission. (2024). Cigna Group Form 10-K for fiscal year ended December 31, 2023, p. 52.
https://www.sec.gov/Archives/edgar/data/1739940/000173994024000005/ci-20231231.htm

Elevance/Anthem/WellPoint

2003 (Anthem): U.S. Securities and Exchange Commission. (2004). Anthem Inc. Form 10-K for fiscal year ended December 31, 2003, p. 37.
https://www.sec.gov/Archives/edgar/data/1156039/000119312504030877/d10k.htm

2003 (WellPoint): U.S. Securities and Exchange Commission. (2004). WellPoint Health Networks Inc. Form 10-K for fiscal year ended December 31, 2003, p. 43.
https://www.sec.gov/Archives/edgar/data/1013220/000104746904007997/a2128273z10-k.htm

Note: Pre-merger profits for Anthem and WellPoint were combined for 2003.

2023 (Elevance): U.S. Securities and Exchange Commission. (2024). Elevance Health Inc. Form 10-K for fiscal year ended December 31, 2023, p. 51.
https://www.sec.gov/Archives/edgar/data/1156039/000115603924000015/elv-20231231.htm

Centene

2003: U.S. Securities and Exchange Commission. (2004). Centene Corporation Form 10-K for fiscal year ended December 31, 2003, p. 18.
https://www.sec.gov/Archives/edgar/data/1071739/000095013704001221/c83064e10vk.htm

2023: U.S. Securities and Exchange Commission. (2024). Centene Corporation Form 10-K for fiscal year ended December 31, 2023, p. 50.
https://www.sec.gov/Archives/edgar/data/1071739/000107173924000037/cnc-20231231.htm

Humana

2003: U.S. Securities and Exchange Commission. (2004). Humana Inc. Form 10-K for fiscal year ended December 31, 2003, p. 23.
https://www.sec.gov/Archives/edgar/data/49071/000119312504035443/d10k.htm

2023: U.S. Securities and Exchange Commission. (2024). Humana Inc. Form 10-K for fiscal year ended December 31, 2023, p. 49.
https://www.sec.gov/Archives/edgar/data/49071/000004907124000012/hum-20231231.htm

Appendix B: Big Six Insurance Lobbying, 2003 and 2023

UnitedHealthcare

2003: OpenSecrets. UnitedHealthcare lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=D000000348

2023: OpenSecrets. UnitedHealthcare lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000000348

Aetna/CVS

2003: OpenSecrets. Aetna lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=D000000296

OpenSecrets. CVS Health lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000025214

Note: The figure cited includes CVS's lobbying on all its segments, not just insurance. Determining the exact amount of CVS Health's lobbying dollars attributable specifically to its insurance-related activities is extremely challenging based on the available data. The company reports lobbying expenditures by broad categories, such as healthcare, pharmacy, and Medicare/Medicaid, but these categories encompass both its insurance and non-insurance activities, including pharmacy benefits management (PBM) and retail operations.

Despite these limitations, analyzing CVS's total lobbying dollars is still useful for this report because their reported lobbying activities are frequently related to healthcare, Medicare/Medicaid, and the Affordable Care Act.

Elevance/Anthem/WellPoint

2003: OpenSecrets. Anthem lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=d000000109#subs

2003: OpenSecrets. WellPoint lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=d000000109#subs

2023: OpenSecrets. Elevance lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000000109#subs

Centene

2007: OpenSecrets. Centene lobbying summary for 2007. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2007&id=D000024670

2023: OpenSecrets. Centene lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000024670

Note: Centene's lobbying efforts began in 2007, so there is no lobbying data prior to that.

Cigna

2003: OpenSecrets. Cigna lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=D000000222

2023: OpenSecrets. Cigna lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000000222

Humana

2003: OpenSecrets. Humana lobbying summary for 2003. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2003&id=D000000652

2023: OpenSecrets. Humana lobbying summary for 2023. https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2023&id=D000000652

CREDITS AND ACKNOWLEDGEMENTS

Write-Off Warrior will continue to research topics related to health care in rural America and beyond.

This includes updating the Preyed On report for 2026, as well as producing state-specific studies on the impact of Medicaid Managed Care programs.

If you are a rural hospital leader who would like to be included in a future report, please email info@writeoffwarrior.com.

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Acknowledgements

The authors would like to acknowledge the participation from numerous rural hospital leaders. We give special thanks to rural health leaders willing to speak out, especially those quoted in this report.

We also wish to thank HomeTown Health and Physicians for a National Health Plan for their contributions to the report.

About Write-Off Warrior

Write-Off Warrior is a research and advocacy firm dedicated to improving and saving rural hospitals and rural healthcare.

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