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Why Washington Must Make Health Care Simpler

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Washington has spent decades trying to make health care more affordable and more accessible. These efforts are vital, but it has overlooked a core problem that Americans feel every day: even when people have coverage, **the health care system is simply too complicated.**

That is true no matter where people get coverage. People with employer-sponsored insurance, Medicare, Medicaid, marketplace plans, or other coverage all run into confusing rules, unclear costs, paperwork, and gaps in information. The details differ, but the experience is often the same: health care is too hard to understand, too hard to navigate, and too hard to use.

That complexity is not a minor annoyance. It is a missing piece of the health care debate. Complexity drives up costs, creates barriers to care, and makes the system less accountable to the people it is supposed to serve. Washington has rightly focused on protecting coverage and lowering costs, but too often the conversation stops there. Washington needs a clearer vision for how health care can work better for people who rely on it.

Today, too many Americans get bills they did not expect, spend hours on the phone trying to fix problems they did not create, struggle to understand what is covered, and delay or skip care because the system is too hard to navigate. And when something goes wrong, patients often cannot tell who is responsible or how to fix it.

A simpler health system should be the next step in any health reform agenda. That means making coverage easier to choose, care easier to use, and costs easier to understand. It also means making the system easier to oversee and hold accountable. People are tired of doing everything right and still getting blindsided by a system that is supposed to help them.

In this memo, we explain why health care is hard to use, why simplicity matters, and how policymakers can make health care easier to choose, use, and pay for.

Why Care is Hard to Use: Three Aspects of Complexity

For most Americans, the problem with health care is not just cost—it is that the system is too hard to use. Even people with good health insurance struggle to figure out where to go for care, what is covered, and what they will owe. ¹ **Complexity shows up at every step in health care: choosing a plan, using coverage, and paying for care.**

- When **choosing coverage**, consumers are asked to make high-stakes decisions with incomplete or unreliable information. Provider networks are often inaccurate or out of

date, making it difficult to find available, in-network care and increasing the risk of unexpected out-of-network costs. ²

- Once enrolled, **using coverage** is often no easier. Patients must navigate a fragmented system where medical records are not shared, care is poorly coordinated, and basic steps can require extra paperwork or approval. In many cases, middlemen now sit between patients and their doctors, influencing coverage decisions and access to treatment. These barriers can delay treatment, frustrate patients and providers, and keep people from getting care in the first place. ³
- **Paying for care** is often just as confusing. Patients rarely know what they will owe before they get care, and even routine services can lead to unexpected bills. One visit can also mean several bills from different providers, making it hard to know what they are charging and why. And when something is wrong, patients can spend hours calling insurers, providers, and billing offices just to fix the problem. ⁴

Recent polling found that 58% of insured adults had a problem using their insurance in the past year, including 60% of adults with employer-sponsored coverage, 58% of adults with Medicaid, 56% of adults with marketplace coverage, and 51% of adults with Medicare. ⁵

That is not just inefficient. It is infuriating. People are trying to choose the right coverage, use the care they need, and pay the bills they owe, but the system makes each step harder than it should be.

Taken together, these challenges mean that having insurance does not guarantee access to affordable care. Instead, patients are left to navigate a system that is not designed around their needs. That is why this issue has political significance. People are angry because the system wastes their time, drains their wallets, and leaves them feeling powerless when they need help.

The Link Between Complexity & Affordability

Any serious affordability agenda has to take on complexity. Lowering prices and expanding coverage matter. But those efforts will fall short if the system remains costly to run and

hard to use. ⁶

Complexity is expensive and it makes it harder to get care. Providers, insurers, and employers spend enormous time and money on billing, coding, prior authorization, claims disputes, and different rules across different plans. None of that makes people healthier. But all of it gets built into the price of health care.

Administrative costs now account for an estimated 15% to 25% of US health care spending. ⁷ That includes roughly \$200 billion a year spent on paperwork needed to bill care, process claims, and approve treatment. ⁸ Prior authorization is meant to prevent unnecessary care, but too often it adds more complexity, delays, and provider burnout while making needed care harder for patients to get. ⁹ Even a basic office visit can trigger a costly chain of billing, coding, insurance review, and follow-up before the patient knows what they owe. Employers pay for that through higher premiums. ¹⁰ Workers pay for it through higher contributions, less take-home pay, and slower wage growth over time. ¹¹

The lack of standardization makes it worse. Every insurer, plan, and provider system has its own rules, forms, codes, and processes. That means more staff time, more paperwork, more appeals, and more confusion.⁹ It is waste—and it becomes part of what everyone pays.⁷

Complexity also gets in the way of care. Patients may not know what is covered, whether a provider is in network, what a service will cost, or what approval they need before treatment can move forward. Those hurdles delay care.³ They also create more calls, more paperwork, and more costs. ¹²

Moving to a Simpler System

People want action on the problems in front of them. They do not want to wait for Washington to rebuild health care from scratch. They want fixes that make health care easier to understand and use: accurate provider directories, clearer explanations of benefits, public reporting of denial rates, upfront cost information, and real help when problems arise. ¹³

Washington has made progress—but not enough. For example:

- The Affordable Care Act (ACA) made it easier to compare coverage by standardizing benefit and coverage information. ¹⁴ Those standards can also make some cost-sharing arrangements easier to compare. But consumers still have to sort through premiums, provider networks, and other plan differences. ¹⁵ And recent rulemaking under the Trump Administration eliminated standardized plan requirements in the

marketplaces, making it harder for consumers to compare coverage options side by side.

- The Trump Administration took a step toward better provider directories ¹⁶ by requiring certain public program plans to make directory information publicly available. But access to data is not the same as accuracy. Too many directories are still incomplete or out of date, making it harder for patients to find care and avoid unexpected out-of-network costs. ¹⁷
- The No Surprises Act reduced some unexpected bills. It protects consumers from certain surprise medical bills and keeps them out of many payment fights between providers and plans. But it did not make billing simpler, nor did it lower costs. ¹⁸ Even with these new consumer protections, too many people still do not know what care will cost until after they get it. ¹⁹

Washington needs to do more. A modern health care agenda should put simplicity alongside affordability and access. That means practical reforms that make coverage easier to understand, easier to use, and easier to navigate without overhauling the system.

The goals are straightforward: make health care easier to choose, easier to use, and easier to pay for. It starts by fixing the moments where people struggle the most. In each area, policymakers can take practical steps that make a real difference for consumers and build toward broader reform.

Step 1: Make It Easier to Choose Care

The first step is making it easier for people to understand and compare their options. Today, choosing a health plan feels like guesswork. Families are expected to compare premiums, deductibles, copays, coinsurance, networks, drug coverage, and out-of-pocket limits without a simple way to see what those terms mean for their care or their costs. And choosing coverage is not a one-time event. People's health needs, jobs, and income can change over time, but coverage is often difficult to compare or adjust.

Start with a simple fix: a standard health plan label.

Like nutrition labels, every plan should present key information in the same clear, easy-to-compare language and format. That should include cost-sharing rules, covered services, drug coverage, provider network information, and common examples of what people might pay for routine care. The ACA already created a foundation for this through the Summary of Benefits and Coverage, which requires plans to provide standardized information about benefits and costs. But that tool should be modernized, simplified, and made more useful for the way people actually choose coverage today.

A standard health plan label, no matter where consumers get coverage, would help people compare plans side by side, understand their likely costs, and avoid coverage that looks affordable but is hard to use when they need care.²⁰ This should be paired with stronger requirements for accurate provider directories and clearer network information, so people know where they can actually get care.

This is a starting point. Policymakers can build on it with other reforms. They can streamline enrollment and eligibility so people do not lose coverage because of paperwork.²¹ They can make coverage more continuous across jobs and life changes, so people have fewer disruptions when they change jobs or face major life changes.²² And they can limit misleading or low-value plans that look affordable upfront but leave families exposed when they need care.²³

Step 2: Make It Easier to Use Care

Having coverage should mean being able to get care without unnecessary hurdles. Today, patients face delays, paperwork, and poor coordination that make the system harder to use.

Start with a basic fix: give patients control of their health information.

People should be able to access their own health records, understand what is in them, and share them with the providers they choose. Too often, a person's medical history is stuck in one provider's system, unavailable when they switch doctors, see a specialist, visit an emergency room, or manage care across multiple conditions. That leaves patients repeating the same information, filling out the same forms, and relying on offices to send records on their behalf.

A single, patient-accessible, interoperable health record would organize information around patients, not providers. It should also allow providers and health plans to share information in real time, so care and coverage decisions can be made with the right information at the right time. That would help providers see the full picture, reduce medical errors, avoid duplicate tests, improve coordination, and make care easier to navigate. In the digital age, patients should not have to rely on offices faxing records back and forth. Federal policy has created a foundation for stronger data sharing, and the tools exist today to move health information securely. But those tools have not been scaled across the health system.²⁴ Policymakers should build on that progress and require the use of proven systems that make health information easier for patients to access, use, and share across their lifetime.

This is a starting point. Policymakers should build on recent efforts to modernize prior authorization by making approvals faster, standardizing forms, and giving patients clear

coverage decisions so they don't have to wait days or weeks for care their doctor already recommended.²⁵ They can make telehealth a stable, reimbursable benefit, especially for patients who face transportation barriers or live in areas with provider shortages.²⁶ And they can provide one clear point of contact when patients run into problems, so people know where to go for help instead of being left to navigate care and coverage problems on their own.

Step 3: Make It Easier to Pay for Care

Paying for care should be predictable and understandable. Today, it is often neither. Patients frequently do not know what they owe until after the fact, and even then, bills can be confusing and difficult to resolve. A bill that arrives weeks or months later is not just a payment problem. It is a trust problem.

Start with a simple fix: require clear, upfront pricing for common services.

Patients should know the expected cost of care before they receive it, with simple, usable information—not estimates buried in fine print. People get estimates before they fix a car or renovate a kitchen. They should not have to get health care first and find out later whether it costs \$50, \$500, or \$5,000.

Federal rules already require hospitals and health plans to disclose certain prices and cost-sharing information. But that information still does not work well for patients. Some hospitals do not comply.²⁷ Even when prices are available, they are often buried in complicated files, reported in different formats, or missing key details about what is actually included. Patients may not know whether a price covers the full episode of care, one part of the visit, or a separate facility or professional charge.²⁸

That is not transparency. Patients should not have to search hospital websites, decode spreadsheets, or know a billing code to understand what they might owe.²⁹

Clear, upfront pricing would make transparency real. For common services and episodes of care, like the birth of a child, patients should be able to see a reliable estimate of costs before receiving care, based on their coverage. They should also receive a clear, personalized estimate before care that explains what their plan is expected to cover, what they are likely to owe, and how providers and health plans arrived at that estimate.³⁰ That would make costs predictable, improve trust, and help families plan for care without worrying that the real bill will arrive months later.

This is a starting point. Policymakers can build toward a system with unified medical bills, so one episode of care does not lead to five different bills from five different places. They can give consumers one account to track and pay health bills, so families can manage costs in

one place instead of chasing paperwork across providers, insurers, and billing offices. And they can set a clear deadline for providers, insurers, and billing companies to resolve billing disputes, so patients are not hit with bills months or years later and medical debt does not follow them into the rest of their financial lives.

Conclusion

Simplifying health care is not just about convenience. It is how Washington can lower costs, improve access, and make coverage work better. A simpler system would make it easier to choose coverage, use care, and understand costs. That is the path to a health care system that works better for patients—and delivers real value for what consumers pay. It is also how policymakers can respond to what people are saying clearly: they are tired of a system that takes their premiums, hides the rules, sends the bill later, and leaves them to sort it out alone.

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