WYOMING MEDICAL SOCIETY

June 18, 2026 - Health Insurance Affordability Taskforce

Overview

Wyoming faces high health insurance premiums as a direct result of the elevated costs inherent in delivering medical services across the state. In this rural and frontier environment, insurance premiums function not as the primary driver of expense, but as a financing mechanism that accounts for established factors such as risk, utilization, and workforce shortages. These costs also incorporate the financial burden of uncompensated care, including charity and bad debt, alongside mandated access obligations under EMTALA, medical malpractice liability, and challenges created by Wyoming's interest in expanding scope of practice for advanced practice professionals.

The **structural inevitability of these high costs stems from Wyoming's unique geography and small population.** As the least populated state, with a landmass 50% larger than New England, maintaining a viable healthcare infrastructure is a significant challenge. Consequently, hospitals, physicians, and insurance carriers must navigate the complexities of a system that is specialized, isolated, and largely shielded from traditional free-market principles.

Grounding Statistics

- According to the Gallup Center on Healthcare Report, Wyoming ranked **39th overall nationally for healthcare experience**. Among some of the most striking findings were:
  - 36% of Wyoming residents avoided a doctor-recommended procedure because they couldn't afford it
  - 34% reported that the distance to medical professionals prevented or delayed care.
- A 2023 BetterWyoming study concluded:
  - Wyoming ranks nearly dead last among the Rocky Mountain states for affordability and accessibility
  - We have the sixth-highest rate of uninsured adults nationally (appx. 16%), and
  - One in ten children has no health insurance - the second-worst rate in the U.S.

Evolution of Insurance Through Time - Added Perspective

Health insurance has changed drastically over time. The evolution can be attributed to a multitude of things, including employer-sponsored coverage, tax policy, federal regulation, advances in medical care, Medicare/Medicaid, and the growth of chronic disease management.

It is true that over time, insurance moved from mainly financing hospital or catastrophic events toward financing access to evidence-based care, including primary care, prevention, screenings, immunizations, and chronic disease management.

EMTALA

It's difficult to fully capture the history of this evolution without including the role and impact of EMTALA. EMTALA stands for the Emergency Medical Treatment & Labor Act and was passed by the U.S. Congress in 1986 and is broadly considered one of, if not the most significant, changes in emergency treatment health policy. EMTALA, simply stated, **creates mandatory obligations for hospitals**, which include:

1. **Providing an appropriate medical screening exam** to anyone who comes to the hospital emergency department requesting examination or treatment,
2. **Maintaining a list of specialists who are "on-call"** should the emergency physicians need them (anesthesiology, surgery, etc)
3. **Providing all necessary treatments, including hospitalization,** determined necessary to stabilize a patient if the hospital determines their condition to be a medical emergency
4. **Facilitating a required transfer** if the hospital is not equipped to adequately treat the condition

Hospital Survey and Construction Act of 1946

Prior to passing EMTALA, the Hospital Survey and Construction Act of 1946, sometimes referred to as the Hill-Burton Act, was in force. This **1946 federal law provided grants and loans to states to construct and modernize hospitals in exchange for those hospitals and facilities providing a reasonable volume of uncompensated care to the poor.** Hospitals were broadly noncompliant with this law, and a practice often referred to as "patient dumping" reached an all-time high in the early 1980's, leading to the passage of EMTALA. Prior to EMTALA, a study found that 87% of emergency transfers to a public hospital occurred due to a lack of insurance or funds to pay for treatment.

Importantly, separate from these federal laws, the Joint Commission on Accreditation of Hospitals and the American College of Emergency Physicians, along with a host of states, independently include language in their regulations requiring covered healthcare providers and physicians to provide care "when medically indicated - regardless of race, creed, sex, nationality, or sources of payment for care."

Right to Emergency Healthcare in the U.S.

Taken and considered together, these laws and regulations establish a right to emergency healthcare in the United States. In other words, Americans understand and appreciate - often reflected in their behavior and market choices - that they can allow symptoms to persist and conditions to worsen when they aren't able to afford early medical treatments and interventions or can't afford health insurance that would pay for those earlier interventions. When the condition reaches the point where it constitutes a medical emergency, patients will be seen and cared for regardless of their ability to pay for the services. Patients know that when they are sick

enough, there is one door to healthcare that will remain open and available to them, albeit the most expensive and inefficient one.

Circling back to the evolution of health insurance, a significant focus of the Affordable Care Act (ACA) involved covering preventive medical services and encouraging patients to take an active role in managing their health from an earlier stage. This approach addresses patient behavior and recognizes that collective costs can be reduced by providing access to evidence-based primary care early on. Such early intervention is far more cost-effective than addressing the substantial downstream expenses that arise from delayed diagnosis, treatment, and medical care.

Example of the Cost of Delayed Care and Cost to the System

Early Diagnosis: When diabetes is caught early (prediabetes or very early Type 2), the annual management cost runs roughly **$4,500 to $5,000 per year** for a person with insurance who takes insulin, sees their doctor regularly, and monitors their glucose. Lifetime direct medical costs for someone diagnosed between ages 45–54 run about **$106,000 — spread over decades**. The CDC notes that regular foot exams and patient education alone could prevent up to 85% of diabetes-related amputations.

Delayed Care Leading to Amputation: The numbers change drastically once diabetes spirals out of control. A foot or leg amputation costs $30,000 to $60,000 in initial hospital costs, plus $40,000 to $60,000 in follow-up care. Major amputations average $73,222 for the hospitalization event alone. But that's just the beginning — for a person with a unilateral lower extremity amputation, the two-year healthcare cost, including initial hospitalization, inpatient rehabilitation, outpatient physical therapy, and prosthetic device purchase and maintenance, is estimated at $91,106 — and **lifetime costs are estimated to exceed $500,000**.

Mortality: The five-year mortality for people with diabetes who undergo a major amputation is estimated at 56.6%. And of those who do survive, only about 25% of major lower extremity amputees are able to ambulate with a prosthetic outside their home.

Path A — early care

Caught early, managed continuously

1. **screening & diagnosis**
   HbA1c test, fasting glucose, prediabetes flagged early
   $148–$300 one-time
2. **lifestyle intervention**
   Metformin, diet counseling, 7–8 office visits/yr
   ~$4,500–$5,000/yr
3. **insulin therapy begins**
   Insulin (~$512/yr), glucose monitoring, supplies
   ~$5,000–$7,000/yr
4. **ongoing managed care**
   Annual foot exams, eye checks, kidney monitoring
   ~$5,000–$9,600/yr

20-yr total (est.) **~$85K–$106K**

5-yr mortality risk	mobility
Low	Fully intact
amputations prevented	**quality of life**
Up to 85%	Good

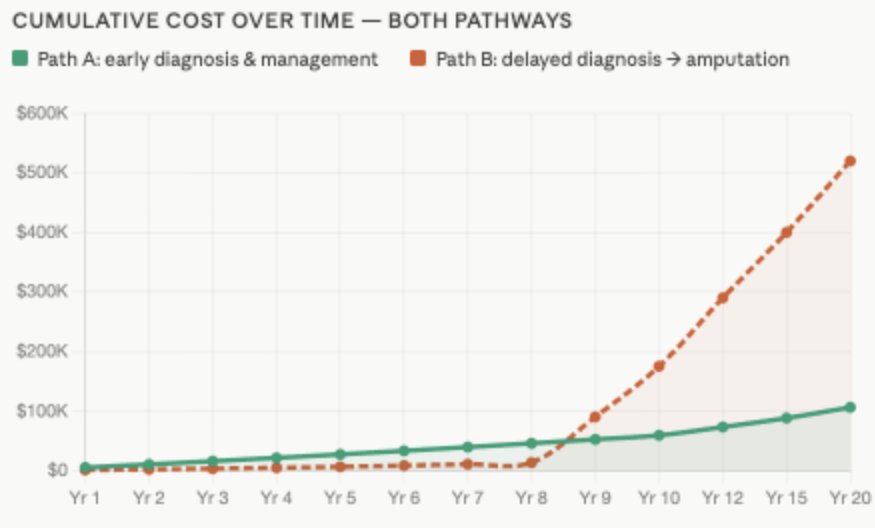
Path B — delayed care

Uncontrolled until crisis; amputation required

1. **years of unmanaged disease**
   High blood sugar, neuropathy, vascular damage building
   Hidden cost in future damage
2. **diabetic foot ulcer / crisis**
   Wound care, ER visits, failed revascularization
   $9B–$13B/yr sector cost
3. **amputation surgery**
   Minor: ~$46K avg. Major (above knee): ~$73K avg.
   $46K–$73K hospitalization
4. **rehabilitation & lifetime care**
   2-yr rehab: $91K. Prosthetics every 3–5 yrs: $50K–$100K each. Phantom pain, PT, home modifications ongoing
   $418K+ after year 2

lifetime total (est.) **$509K–$700K+**

5-yr mortality risk	mobility
56.6%	Severely limited
ambulatory post-amp	**quality of life**
Only 25%	Significantly reduced



<u>Health Insurance is Not Car Insurance - A Misleading Comparison</u>

The common comparison between health and auto insurance is a flawed analogy that requires careful scrutiny. In the automotive world, insurance functions purely as a mechanism for risk mitigation. Furthermore, vehicle ownership is a discretionary choice rather than a necessity of existence, yet those who choose to own a car are legally mandated to carry coverage to protect others from potential harm. While the responsibility for routine vehicle maintenance rests solely with the owner, who must personally bear the consequences of mechanical neglect or catastrophic failure, health insurance operates under a fundamentally different framework. Although the idea of individuals managing their own routine care costs without insurance intervention may seem appealing, it is vital to recognize that these two systems are built on incompatible principles.

The healthcare landscape operates on an entirely different social contract. Unlike the owner of a neglected vehicle, an individual who fails to maintain their health and subsequently suffers a medical emergency is entitled to care. Society has determined—and Congress has codified—that every American has a right to essential emergency services regardless of their financial status. When patients receive treatment they cannot afford, the financial burden does not simply vanish; it is redistributed across society through higher insurance premiums, increased taxes for uncompensated care, and broader community costs. This fundamental guarantee of service creates a relationship between the public and the healthcare system that simply does not exist in the context of automotive maintenance.

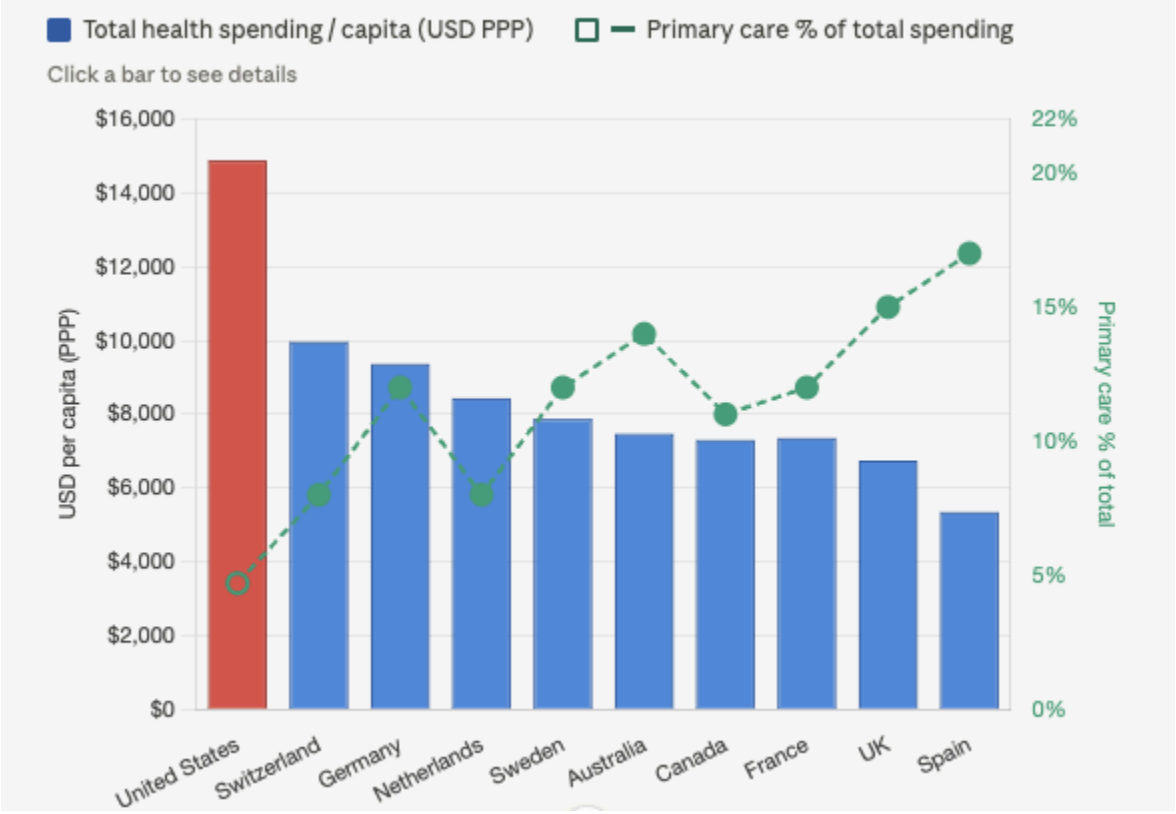
<u>Cost of Care and the Value Proposition of Primary Care</u> (WMS October 2022 Article - K. Schamber, MD)

Primary Care Workforce Statistics - a connection to cost and a nod toward potential solutions:

- Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. (AAFP Importance of Primary Care)

    - In the U.S. an increase of one PCP per 10,000 people found:
        - Decrease in both infant and adult mortality
        - 3.2% reduction in low birth weight
    - Patients with a long-term relationship with a PCP are less likely to visit the ED
    - U.S. adults with a PCP had a 33% lower health care costs
- Despite the significant role that primary care plays in our health system, primary care accounts for a mere 4.7% of total health care spending in the United States. The average of the other High-Income Nations (OECD average) is ~14%. Interestingly, all of those countries included in the OECD average have longer life expectancy
    - The U.S., on average, spends half the amount as other industrialized nations on primary care as a percentage of total health care spending.
- In some developed nations, upwards of 85% of their physician workforce is practicing within primary care, compared to the United States, which, as of 2019, reported only 38% of its physician workforce in primary care.
- Increasing spending on primary care by 37% over four years - 2008-2012 (Rhode Island study) saw a 14% decline in the total health care expenditures

Peterson-KFF Health System Tracker (Healthcare price and use indices)
Peterson-KFF Health System Tracker (US Health Spending Compared to other countries)



PHYSICIAN EMPLOYMENT/SYSTEM CONSOLIDATION: Workforce shortages are cost drivers, not just access problems. Physician employment trends paint a complicated and nuanced picture, but one worth evaluating within the context of the cost of healthcare.

- The Physicians Advocacy Institute / Avalere rural report found that **between 2019 and 2024, rural areas nationally lost nearly 2,500 physicians, saw nearly 3,300 rural medical practices close, and had a 43% decline in independent physicians.** It also reported that by January 2024, 76% of rural physicians were employed by hospitals, health systems, or corporate entities, and 61% of rural medical practices were owned by non-physicians.

Consolidation in rural areas is often necessary and key to workforce survival

- In rural communities, hospital employment of physicians is often a survival strategy. A local hospital may employ physicians because independent practice has become financially or administratively unsustainable due to call coverage obligations, EMR costs, and the challenges of recruitment.

Physician Employment Trends Contribute to the Cost of Care

- There is a growing body of evidence supporting that when independent physician practices are acquired by hospitals or large health systems, the same services often become more expensive - not necessarily because the physician's work changed, but because **the ownership, billing structure, referral patterns and negotiating leverage changed. Estimates range anywhere from 11% - 17% increase in cost of care associated with physician employment or consolidation.**
- In a 2025 GAO report to Congress, the U.S. Government Accountability Office (GAO) concluded that physician consolidation with hospital systems "can lead to increased spending and prices," including higher Medicare spending from services shifting into more expensive hospital-based settings and higher commercial prices after hospital-physician consolidation. The GAO also noted that studies generally found no change or a decrease in quality, and that access effects are less well studied.
- Some interesting statistics include:
    - GAO cited MedPAC's finding that **shifting office visits from physician offices to hospital outpatient departments increased traditional Medicare spending by $615 million and beneficiary cost sharing by $150 million from 2015 to 2019**.
    - On the commercial insurance side, GAO found that studies generally show higher prices after hospital-physician consolidation. Examples included a 17% increase in office-visit prices, 3% to 5% higher inpatient hospital prices, and childbirth-related commercial price increases of 15% for physician services and 3% for hospital services after consolidation between hospital systems and OB/Gyn physicians.
    - In 2025, a JAMA Health Forum study looked specifically at primary care and found that hospital-affiliated primary care physicians increased from 25.2 in 2009 to 47.9% in 2022. The same study found that office-visit prices were 10.7% higher for hospital-affiliated primary care physicians than for independent primary care physicians, after adjustment.
    - A National Bureau of Economic Research summary of a Yale-led study on hospital acquisitions of physician practices found that, after integration, prices increased without clear evidence of quality improvement. In the labor and

delivery context, physician prices rose 15.1%, and hospital prices rose 3.3% in the two years after integration.
    - Finally, the AMA reported that the share of physicians in private practice fell from 60.1% in 2012 to 42.2% in 2024, while the share working in hospital-owned practices rose from 23.4% to 34.5% over the same period. The AMA also reported that direct hospital employment or contracting doubled from 5.6% in 2012 to 12% in 2024.
- When a physician moves from independent practice to hospital or health-system employment, several things can happen:
    - **The same office-based service may be billed through a hospital outpatient department,** which can add a facility fee or trigger higher site-of-service payment.
    - **The hospital or health system may gain negotiating leverage with commercial insurers**, especially if it controls both the hospital and a large share of local physicians.
    - **Referral patterns may shift inward,** keeping imaging, labs, procedures, and specialty care within the system, sometimes in higher-cost settings.

None of this data is intended to imply that hospital employment of physicians should be blamed or vilified. In many, if not most, cases, physician employment was, and still is, a necessity for physician sustainability. While the evidence supports the argument that movement of care from independent physician practices into hospital-owned or health-system-owned settings is a documented cost driver, it must also be recognized and appreciated that in small, rural communities, these employment relationships are the reason small communities still have a physician presence.

The evidence suggests that when care moves from independent clinics to hospital-based clinics, the prices associated with the same care often rise even though the underlying clinical service remains the same. This is largely attributed to higher site-of-service payments and facility fees (a result of cost shifting created by much of what was discussed earlier with uncompensated care), and stronger negotiating leverage with commercial insurers.

In Wyoming, we have to recognize two truths at the same time. First, physician employment by hospitals may be necessary in some communities to preserve access. Second, the national evidence shows that consolidation can increase prices, especially when services move into higher-cost hospital outpatient settings. We have to be careful in policy discussions not to punish rural integration that oftentimes provides one of the only lifelines available to preserving physician availability, yet we must be educated in understanding the impact of the loss of independent physician practice within our communities as a real and documented cost driver.

In conclusion, The State cannot solve premiums without addressing the uninsured, underinsured, rural delivery costs, and workforce together. We also can't do any of that without reliable, trusted, and objective data that is state-specific.

Wyoming’s health insurance costs are the visible symptom of deeper delivery-system pressures. If we want lower premiums, we must reduce avoidable uncompensated care, strengthen rural access,think differently about the value of primary care, strategically invest in workforce, keep patients out of crisis, and make sure public obligations like EMTALA are financed honestly, rather than through an obscure and opaque system baked into the commercial insurance market.