AUGUST 2025

SICK PROFITS

HOW HEALTHCARE COMPANIES HAVE GOTTEN RICHER FROM THE TRUMP TAX CUTS WHILE SUBMITTING THEIR CUSTOMERS AND PATIENTS TO HIGHER COSTS AND SUBSTANDARD CARE

AMERICANS FOR TaxFairness

Community Catalyst

ACKNOWLEDGMENTS

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Special thanks to the Institute on Taxation and Economic Policy (ITEP) for the analyses that form the basis for this report's tax-related data.

COMMUNITY CATALYST is a national organization dedicated to building the power of people to create a health system rooted in race equity and health justice and a society where health is a right for all. Together with partners, we're building a powerful, united movement with a shared vision of and strategy for a health system accountable to all people.

AMERICANS FOR TAX FAIRNESS (ATF) is a diverse campaign of more than 420 national, state and local endorsing organizations united in support of a fair tax system that works for all Americans. It has come together based on the belief that the country needs comprehensive, progressive tax reform that results in greater revenue to meet our growing needs. This requires big corporations and the wealthy to pay their fair share of taxes, not to live by their own set of rules. ATF is a project of the New Venture Fund—a section 501(c)(3) non-profit organization.

INTRODUCTION

Seven of America's biggest healthcare corporations have dodged over $34 billion in collective taxes since the enactment of the 2017 Trump-GOP tax law that Republicans recently succeeded in extending. Meanwhile, patients and customers of those big firms face higher prices and diminished care and service. In fact, the same law that extended the 2017 tax cuts–which mostly benefits the wealthy–is estimated to result in nearly 15 million people losing their healthcare coverage, including 10 million dropped from Medicaid and the rest from the Affordable Care Act marketplace.

> **"SEVEN OF AMERICA'S BIGGEST HEALTHCARE CORPORATIONS HAVE DODGED OVER $34 BILLION IN COLLECTIVE TAXES SINCE THE ENACTMENT OF THE 2017 TRUMP-GOP TAX LAW.**

Without reforms to our tax code, those companies stand to avoid even more taxes in the future, helping them grow ever more rich and powerful while their customers and patients suffer. Those are among the findings of a new joint report from Americans for Tax Fairness (ATF) and Community Catalyst based in part on the tax analysis of the Institute for Taxation and Economic Policy (ITEP).

As the tax savings for these seven healthcare firms and the resulting benefits for their executives and stockholders have risen, so have the costs–both financial and personal–paid by their customers and patients. The health insurers have all denied coverage for legitimate care; hospitals have jacked up prices; and healthcare facilities have been found liable for patient harms.

Congress should demand both more in tax revenue and better patient care from these highly profitable corporations. The corporate tax rate should be raised, and special breaks these and other firms use to lower their tax bills–such as the stock options loophole and the shifting of profits offshore–should be eliminated. Healthcare corporation profitability should not come before quality of patient care. In healthcare more than almost any other industry, the search for ever higher earnings threatens the wellbeing and lives of the American people.

THE COMPANIES EXPLOITING THE HEALTHCARE SYSTEM FOR BIG PROFITS

The seven firms–four health insurance companies, two hospital operators and CVS Healthcare, which in addition to its signature pharmacy chain owns the insurer Aetna and various clinics–saw their average annual collective profits rise by 75%, from around $21 billion to roughly $35 billion, between the four-year stretch prior to the law's enactment and the seven years after. Yet, together these companies paid essentially the same average annual federal income taxes in the latter period as the former, representing a collective tax savings of $34 billion due to the law.

The other six corporations in the study are: vertically integrated health companies best known for their insurance products Centene, Cigna, Elevance (formerly Anthem), and Humana; hospital owner HCA Holdings; and Universal Health Services, which owns hospitals and behavioral health centers.

The 2017 Trump tax law cut the corporate tax rate by two-fifths, from 35% to 21%, which will cost an estimated $1.4 trillion in lost revenue over the law's first decade. Congressional Republicans who recently succeeded in extending other provisions of the law that otherwise would have expired at the end of 2025 rejected raising the corporate rate to help pay for the $4.5 trillion in extensions. Indeed, they used the extension bill to loosen a trio of business tax-deduction rules that will add almost $600 billion to the bill's 10-year cost.

Contrary to the promises made by the 2017 tax law's advocates, healthcare corporations (like the rest of Corporate America) failed to use their tax savings to lower costs for customers or meaningfully boost worker pay. Instead, much of their windfall was used to hike the salaries of top executives and increase shareholder payouts through stock buybacks and dividends.

> **“ HEALTHCARE CORPORATIONS FAILED TO USE THEIR TAX SAVINGS TO LOWER COSTS FOR CUSTOMERS OR MEANINGFULLY BOOST WORKER PAY.**

The average annual compensation of the half dozen highest-paid employees at the seven firms–beginning with CEOs–jumped by almost $100 million, or 42%, between the last three years before the law was in effect and the seven since it's been on the books. (Meanwhile, the median wage of workers at the seven companies rose by $14,000 between 2017 and 2024, a relatively modest 24.8% increase that's only a little over half the percentage boost enjoyed by the firms' top bosses.)

Shareholders made out even better than the execs. While stock buybacks–which raise the value of shares remaining in investors' hands–rose by about the same 42% as C-suite pay, dividends more than doubled, up 133% to an average of $5.6 billion in the first seven years of the law.

THE TRUMP-GOP TAX LAW'S WINDFALL FOR HEALTHCARE CORPORATIONS

The centerpiece of the 2017 Trump-GOP tax law was a steep reduction in the corporate tax rate, from 35% to 21%. An ITEP study last year of nearly 300 consistently profitable corporations found that in just its first four years, the Trump law saved those firms a collective $240 billion.

Healthcare companies were among the biggest beneficiaries: five of the firms in this current study each saved over $3 billion in federal taxes over those four years. The ITEP study covered corporate tax savings through 2021; in the three years since–through 2024–additional tax savings have pushed individual totals among the seven healthcare companies in this study above $5 billion and even $7 billion.

> "FIVE HEALTHCARE FIRMS EACH SAVED OVER $3 BILLION IN FEDERAL TAXES FROM 2018-2021.

Though the rate cut was the principal source of all those corporate tax savings, other provisions and omissions in the law also helped cut the healthcare companies' taxes.

One giant loophole the law failed to close was in the tax treatment of stock options. An option is the right to buy or sell a commodity at a future date at a predetermined price. Corporations often award options to buy their stock at what's presumed to be a favorable future price to their top executives as compensation. The tax loophole is in how they account for those option awards as a business expense.

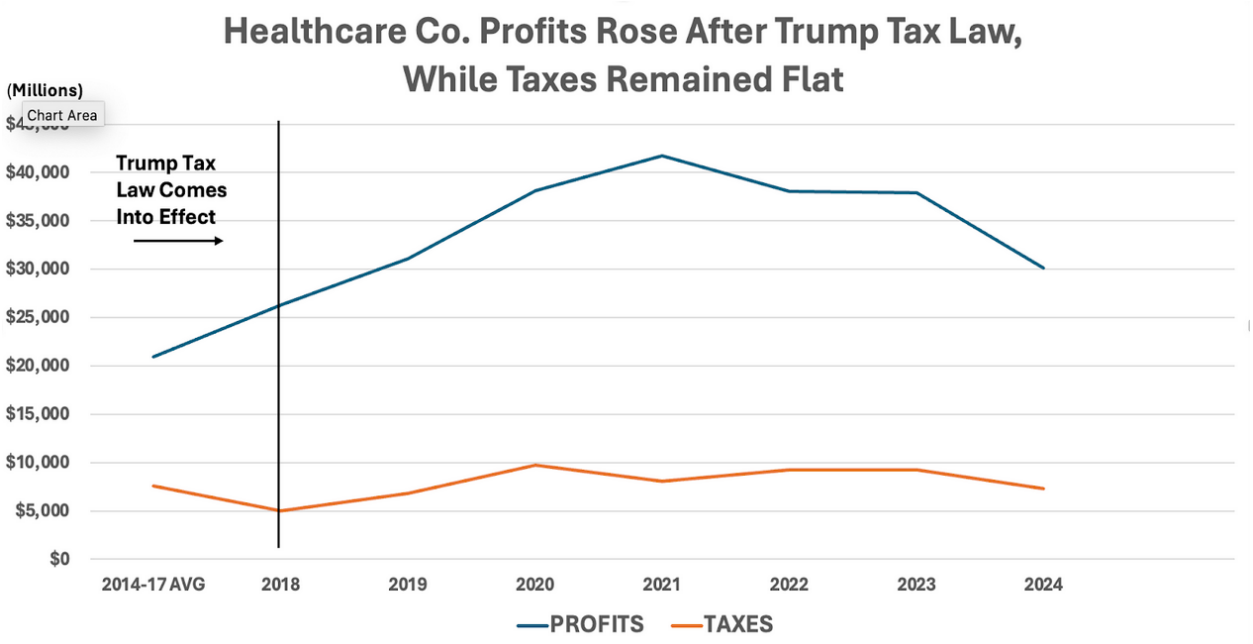
When figuring their "book" earnings–the numbers they show Wall Street–corporations assign these options a value far below what they ultimately report to the IRS. The result is higher profits to attract investors, and lower taxable profits to reduce tax bills. Several of the companies in this study used the stock options loophole to avoid hundreds of millions of dollars in federal and state taxes.

Another defect of the law was its failure to meaningfully curb the ability of corporations to dodge U.S. taxes by shifting profits and sometimes actual production offshore.

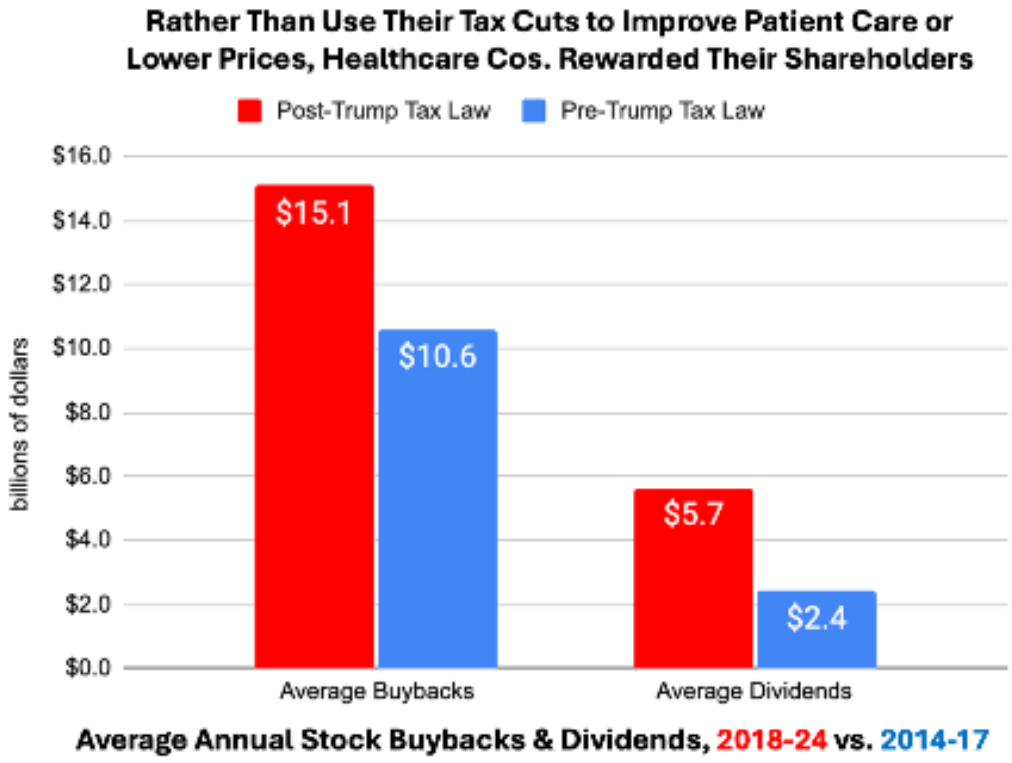
Under the rules in effect before the Trump law, all the profits of American multinational firms were subject to U.S. taxes, wherever they were made–or importantly, were claimed to be made, since companies often used accounting maneuvers to shift what were really domestic earnings offshore. But corporations had an out: those foreign profits weren't actually taxed by the U.S. until they were brought home. So American firms had trillions of dollars of earnings sitting offshore (although that was often an accounting illusion also) on which they owed up to $750 billion in U.S. taxes.

The Trump law ended the U.S. taxation of foreign profits made by American firms (though it included several, mostly ineffective provisions meant to prevent a wholesale shift of production to other countries to avoid taxes). The law also finally taxed all the existing profits sitting offshore, but at a sharp discount to the 35% that was owed when the profits were made.

Since the change in the tax treatment of the foreign profits of American firms, there has been less attention paid to offshore tax-haven subsidiaries set up by U.S. companies. But in the last comprehensive ITEP report on the practice just before the new law was enacted, several of the healthcare companies in this study were found to have such subsidiaries, including in well-known havens like Bermuda, Switzerland, and the Cayman Islands.



Source: Americans for Tax Fairness



Source: Americans for Tax Fairness

HOW HEALTH INSURANCE COMPANIES MAKE MONEY DENYING CARE

Although there is little transparency around the issue, health insurance claim denials appear to be rising. Claim denials often result in medical debt, which affects over four in ten U.S. adults and is the leading cause of bankruptcy. In addition, these denials can disrupt treatment for chronic medical conditions, delay or deny access to lifesaving care, and lead to avoidable complications–or death. All this suffering is caused because insurance companies reap more in profits by paying out less in claims.

One survey found that, in the previous 12 months, nearly half of insured adults experienced difficulty getting their health insurance company to pay for care that they had thought was covered. Specifically, 18 percent of insured adults reported that their health insurance did not pay for care that they received, and 27 percent reported that their health insurance paid less than they expected for a medical bill. Partially or completely denied insurance claims can harm both financial and physical wellbeing. Of insured adults who experienced a problem with their insurance, 28 percent reported paying more than expected, and 15 percent reported a decline in their health.

Health insurance premiums have generally risen at a higher rate than inflation. Combining these

premium increases with high rates of prior authorization refusals and claim denials–that is, charging more while providing less coverage–can be very lucrative for insurance companies and their bosses. While many beneficiaries struggle to afford the health care they need, each of the health insurance companies described in this report paid their CEOs over $20 million in 2024 (in Humana's and CVS's case, split between two successive occupants of the top job).

THE DISADVANTAGES OF MEDICARE ADVANTAGE

Medicare Advantage plans are private health-insurance carriers paid by the federal government to provide Medicare-covered benefits. Unlike the fee-for-service model in traditional Medicare, however, Medicare Advantage plans receive "capitated payments" for beneficiaries and are responsible for coordinating care. Capitated payments means the companies are paid a fixed amount per patient enrolled. If the Medicare Advantage plan's payments for a patient's medical expenses exceed that capitated amount, the plan loses money; if expenses come in under the capitated payment, it makes money.

To manage care and control costs, Medicare Advantage plans may require prior authorization for certain medical items and services. Denying prior authorizations–or just delaying decisions until proposed treatments are abandoned–is a good way of keeping below the per-patient government payments and thus boosting corporate profits. Medicare Advantage prior authorization denials have garnered significant public attention.

> "DENYING PRIOR AUTHORIZATIONS IS A GOOD WAY OF BOOSTING CORPORATE PROFITS.

By contrast, traditional Medicare–the type provided directly by the government–requires prior authorization for only a limited set of services. In 2023, the total number of prior authorizations for traditional Medicare was under 400,000, while the total number for Medicare Advantage was close to 50 million. The American Medical Association believes that "prior authorization is overused and existing processes present significant administrative and clinical concerns."

The Office of Inspector General (OIG) of the Department of Health and Human Services–which oversees Medicare–emphasized that the "central concern" about capitation payment models like the one used by Medicare Advantage is that, absent appropriate oversight and regulation, plans may increase profits by improperly denying coverage.

Unfortunately, Medicare Advantage plans appear to be doing just that. For instance, of the prior authorization denials that the OIG examined, over 13 percent—more than one in eight—requests

met Medicare coverage rules. Significantly, most Medicare Advantage denials are overturned when they are appealed, raising questions about whether Medicare Advantage plans are complying with their coverage obligations or just reflexively saying "no" in the hopes there will be no appeal.

Another concern is that Medicare Advantage insurers will increase their profits by making patients look sicker than they are. The amount that the government pays Medicare Advantage insurers for each patient depends on the health of each beneficiary. Many of the largest Medicare Advantage insurers–including Cigna, Elevance, Humana, and CVS Health–have fraudulently inflated diagnosis codes to collect bigger payments from the government, or been accused of doing so.

As the New York Times noted: "The additional diagnoses led to $12 billion in overpayments in 2020, according to an estimate from the group that advises Medicare on payment policies [...] —enough to cover hearing and vision care for every American over 65." This is an important comparison because while traditional Medicare does not cover most dental, hearing and vision care, many Medicare Advantage plans do. That's one reason beneficiaries are increasingly choosing Medicare Advantage over traditional Medicare. However, Medicare Advantage's ability to offer additional coverage for dental, hearing and vision care is not because the system is somehow more cost-effective. Medicare Advantage costs the government significantly more than traditional Medicare, including tens of billions of dollars they are not entitled to receive.

HOW HEALTH PROVIDER ORGANIZATIONS RAISE PROFITS BY OVERCHARGING AND UNDERSTAFFING

The United States spends more on healthcare per person than any other wealthy country. At the same time, the U.S. has worse health outcomes on many measures, including life expectancy, infant mortality, maternal mortality, and survival from chronic diseases. Of course, many factors influence these outcomes, including a higher poverty rate than other developed nations. But even though some medical providers like rural and Medicaid-dependent hospitals are struggling financially, a big source of the high cost of healthcare are the high profits engineered by the huge corporations that dominate the field.

One of the most profitable corporate healthcare providers in this current report is significantly more expensive than comparable entities, and another has been accused of illegally overcharging state and federal government programs. Their profits don't just come from higher prices, though: two of the most profitable providers have been frequently cited by regulatory authorities for understaffing and patient-safety violations. Despite this troubling combination of charging more but spending less on patient care, these entities have nonetheless enjoyed significant savings under the 2017 Trump-GOP tax cuts–a third source of higher earnings. Despite cutting spending on healthcare and policy changes that will cause nearly 15 million people to lose health coverage, the recent extension and revision of that law tellingly did not include a reduction or elimination of the big corporate tax cuts that have helped healthcare corporations rack up such high profits.

THE SEVEN BIGGEST HEALTHCARE TAX DODGERS

Following are profiles of seven healthcare companies that have so far saved the most from the Trump tax law.

Photo: Michael Conroy/AP

ELEVANCE (FORMERLY ANTHEM)

BRANCH OF HEALTHCARE INDUSTRY: Predominantly insurance, with subsidiaries in specialty pharmacy and provider services

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $7.4 billion

In its first seven years, the 2017 Trump tax law reduced the tax bill of health insurer Elevance (formerly known as Anthem) by a total of $7.4 billion. Elevance, the nation's second largest health insurance company, has used the "stock options loophole" to avoid hundreds of millions of dollars in federal and state taxes over the last few decades.

Elevance used some of its tax savings to boost its average shareholder dividend payouts by more than 80% between the four years before the Trump tax law and the seven years following it. The company has sent out, on average, over a billion dollars of these periodic payments every year to its mostly wealthy investors since the first Trump tax law was enacted.

In 2023, Elevance's Anthem Medicare Advantage plans tied with Humana's for the highest number of prior authorization determinations per enrollee. As noted above, the more insurance companies demand prior authorization for medical treatment, the more opportunity the companies have to save money by denying the treatment. Notably, of the Anthem prior authorization denials that were appealed, over 71 percent were overturned–indicating that many

of Anthem's prior authorization denials were improper and unnecessarily delayed or denied care that the beneficiary was entitled to receive.

In May 2025, the Department of Justice (DOJ) alleged that Elevance paid hundreds of millions of dollars in illegal kickbacks to brokers in exchange for enrolling patients in its Medicare Advantage plans. Specifically, the DOJ alleged that Anthem paid for brokers' commitments to steer Medicare beneficiaries to Anthem's Medicare Advantage plans, even though the brokers claimed to be acting in the best interest of Medicare beneficiaries.

In 2020, the DOJ alleged that Anthem fraudulently inflated claims filed for reimbursement from the Medicare program. Specifically, the government alleged that the company received higher risk-adjusted payments for Medicare Advantage than appropriate due to inaccurate and inflated diagnosis information, which allowed Anthem to "obtain millions of dollars in Medicare funds to which it was not entitled."

In a study of CEO compensation at the largest health plans, Elevance's CEO pay package ranked fifth, with nearly $20.5 million in total compensation in 2024. The ratio of CEO pay to median employee salary at Elevance was 370:1, the highest ratio of the insurance companies in this study.

Photo: Kristoffer Tripplaar/Alamy

CENTENE

BRANCH OF HEALTHCARE INDUSTRY: Insurance (with behavioral health and PBM subsidiaries)

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $7.3 billion

The first Trump-GOP tax law in its initial seven years gifted Centene, the nation's third largest

health insurer, $7.3 billion in tax savings. The last comprehensive report on corporate offshore tax avoidance by ITEP found that Centene maintained two subsidiaries in the tax haven of the Cayman Islands. Centene has used the "stock options loophole" to avoid tens of millions of dollars in federal and state taxes over the last few decades.

Those huge savings from the first Trump tax law prompted an explosion in the company's stock buyback program. Centene on average repurchased 20 times more shares in the years following enactment of the law as it did in the four years preceding it. It bought back over $3 billion worth of stock in 2024 alone.

> "CENTENE ON AVERAGE REPURCHASED 20 TIMES MORE SHARES IN THE YEARS FOLLOWING THE ENACTMENT OF THE TRUMP-GOP TAX LAW AS IT DID IN THE FOUR YEARS PRECEDING IT.

Centene's top executives were undoubtedly among the stock investors who benefitted from these buybacks, since such big bosses tend to be big shareholders. In addition, they were paid in the first seven years of the 2017 Trump tax law annual compensation that averaged almost half again as much as in the four years before the law. Total pay averaged a total of more than $60 million in the years following the tax plan being signed into law.

In 2023, Centene's Medicare Advantage plan denied nearly 14 percent of all prior authorization requests, the highest proportion of prior authorization denials of any Medicare Advantage plan. At the same time, an incredible 93.6 percent of Centene prior authorization denials that were appealed were overturned–indicating that most Centene prior authorization denials are improper and unnecessarily delayed or denied care that the beneficiary was entitled to receive.

As of March 2025, Centene had agreed to pay more than $1 billion in settlements to at least 20 states over allegations of overcharges to Medicaid through its pharmacy benefit manager operation. Two holdouts are Georgia and Florida, which do not appear to have reached an agreement with Centene, despite hiring a law firm to pursue overbilling allegations years ago. Notably, after the law firm was hired to pursue overbilling allegations in Georgia and Florida, Centene and its political action committee contributed at least $2 million to campaigns of candidates of both political parties, state party organizations, and political action committees in those two states.

In a study of CEO compensation at the largest health plans, Centene ranked fourth, paying its CEO total compensation of over $20.6 million in 2024.

CVS HEALTH

BRANCH OF HEALTHCARE INDUSTRY: Conglomerate (pharmacies, insurance, clinics)

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $7.3 billion

CVS Health is best known for its pharmacy chain, but it also owns the Aetna health insurance company and runs a pharmacy benefits business and health clinics. It is the second-largest healthcare company in the United States. It saved $5.7 billion in taxes in the initial seven years of the first Trump tax law.

CVS Health has used the "stock options loophole" to avoid hundreds of millions of dollars in federal and state taxes over the last few decades.

The average annual compensation of the company's handful of top executives shot up by over 75% between the four years before the Trump tax law and the seven years after. At an average of over $76 million, the annual pay of the top bosses at CVS after the first Trump law is the highest among the seven companies in this study.

Shareholders were rewarded with annual dividend payments more than 75% larger in the post-Trump-law years as in the four years before the law. CVS paid out on average more than $2.7 billion of dividends in each of those seven years.

CVS's health insurance company, Aetna, has been accused of improperly denying insurance claims. In 2024, Aetna agreed to pay $2 million to settle a lawsuit alleging that it required LGBTQ beneficiaries to pay more out-of-pocket for fertility treatments than heterosexual beneficiaries. In 2023, Aetna agreed to pay up to $3.4 million to settle a proposed class action lawsuit alleging that it wrongfully refused to cover proton beam therapy for cancer patients. In 2020, California ordered Aetna to stop wrongfully denying payment for emergency room claims and fined Aetna $500,000 for repeated violations. This followed a 2019 California state investigation finding that 93 percent of the company's emergency claims sampled were wrongfully denied.

CVS acquired Aetna in 2018, but the insurer has faced allegations of improper claim denials for years. In 2019, Aetna settled a lawsuit in which a company medical director said under oath that he never looked at patients' records in deciding whether to approve or deny coverage. The terms

of the settlement are not public, but the lawsuit prompted a California investigation of Aetna's practices in denying claims and requests for prior authorization. In addition, an Oklahoma jury awarded $25.5 million in 2018 to the family of a cancer patient who was denied coverage by Aetna, finding that Aetna "recklessly disregarded its duty to deal fairly and act in good faith."

Like Elevance, Aetna has been accused of abusing the Medicare Advantage program. In March 2025, the Department of Justice (DOJ) alleged that Aetna paid illegal kickbacks to brokers to drive enrollments in its Medicare Advantage plans. The complaint also alleges that Aetna conspired with the brokers to avoid enrolling disabled beneficiaries, who they believed would be less profitable.

Like many Medicare Advantage insurers, CVS Health has come under scrutiny for inflated payments from the government. In 2024, the Department of Health and Human Services Office of Inspector General (OIG) estimated that, based on an audit of selected diagnosis codes, CVS Health subsidiary HealthAssurance Pennsylvania received at least $4.2 million in overpayments for 2018 and 2019. Specifically, the OIG found that the vast majority of diagnosis codes audited were not supported by the medical records and resulted in overpayments to HealthAssurance.

CVS also owns Caremark Rx, a pharmacy benefit manager (PBM) that is supposed to negotiate with pharmacies on behalf of its clients for lower drug prices. However, since CVS also owns a pharmacy, concerns have been raised about whether its PBM truly has an incentive to reduce drug costs. In 2024, the House of Representatives' Oversight and Accountability committee reported that the three largest PBMs—including CVS's Caremark Rx—steered patients to their own pharmacies and often increased prices. In 2025, the Federal Trade Commission (FTC) reported that the three largest PBMs—including Caremark Rx—"hiked costs for a wide range of lifesaving drugs, including medications to treat heart disease and cancer."

CVS paid its outgoing CEO Karen Lynch over $34.4 million in 2024, the second-highest compensation package of all the major insurers, even though Ms. Lynch left the company in October 2024. Incoming CEO David Joyner received total compensation of over $17.8 million in 2024.

CVS more than doubled its profits in 2023 compared to 2022, its earnings soaring from $4.1 billion to $8.3 billion. Despite that massive windfall, CVS hired zero additional employees and actually cut its median annual wage by almost $900. It was wealthy investors who reaped the reward, with CVS buying back $2 billion worth of its own stock—helping boost its market value by over 9%—and paying out over $3 billion of dividends.

> **"DESPITE ITS MASSIVE WINDFALL, CVS HIRED ZERO ADDITIONAL EMPLOYEES.**

HCA HOLDINGS

BRANCH OF HEALTHCARE INDUSTRY: Hospitals

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $5.6 billion

Hospital operator HCA Holdings, the largest for-profit hospital chain in the country, avoided $5.6 billion in federal taxes over the initial seven years of the first Trump tax law.

HCA's tax dodging predates that law. In one year earlier this century, HCA effectively got a tax refund of $182 million (or paid a negative tax rate of 5.7%) despite $3.2 billion in profits. HCA has been one of the biggest exploiters of the "stock options loophole," avoiding over $800 million in federal and state taxes over a nine-year stretch. The loophole allowed it to dodge $128 million in 2018 alone.

The company avoided another $80 million in taxes in 2018 thanks to the Trump tax law's "accelerated depreciation." This loophole allows companies to reduce their taxes by immediately writing off big-ticket purchases rather than deducting the purchase price gradually over several years (in accordance with normal accounting practices) to better reflect the ongoing value of buildings, equipment, vehicles and other long-term investments.

The second Trump-GOP tax law that was recently enacted restored accelerated (or bonus) depreciation, which means HCA and other healthcare corporations will be able to use this loophole in the future. The loophole's 10-year cost in lost public revenue is over $360 billion.

The last comprehensive report on corporate offshore tax avoidance by ITEP found that HCA maintained 10 subsidiaries in foreign tax havens, including Bermuda and Switzerland.

HCA's bounty of tax savings from the first Trump law apparently prompted the company to start paying dividends (it had paid none in the four years before the law's enactment). The company's shareholders have pocketed over $3.8 billion of dividends since the 2017 GOP tax plan became law. But those payouts didn't crimp the stock buybacks HCA has been conducting all along: average annual share repurchases more than doubled between the pre- and post-law periods. The corporation has bought back almost $10 billion worth of shares in the last seven years.

These growing stockholder payouts came as HCA was widely and plausibly accused of sacrificing patient care and safety in the name of higher profits. In 2023, NBC News aired a remarkable six-part series detailing staffing shortages, facility failures and patient harms at HCA owned facilities across the nation.

> “ GROWING STOCKHOLDERS PAYOUTS CAME AS HCA WAS WIDELY AND PLAUSIBLY ACCUSED OF SACRIFICING PATIENT CARE AND SAFETY IN THE NAME OF HIGHER PROFITS.

The NBC reports relied heavily on the testimony of doctors, nurses and other employees of HCA. Some spoke on the condition of anonymity, but many of them risked retribution by allowing their names to be used, indicating the seriousness of the charges. They described (and often documented) roaches in the operating room, leaking ceilings, essentially unmonitored vital signs, overworked nurses, overcrowded emergency rooms, closed departments and other threats to patient health and safety. Two unions representing HCA staff–the Service Employees International Union (SEIU) and National Nurses United (NNU)–have also been compiling ongoing reports of staffing shortages and other problems at HCA facilities.

But it’s not just HCA workers and their representatives who have noted the hospital chain’s deficiencies. The federal government’s Centers for Medicare and Medicaid Services (CMS) has ranked 70% of HCA hospitals in Florida–where it has 46 facilities–as below average in quality, receiving only one or two out of five stars. None received the top five-star rating.

HCA also boosts profits by raising prices. HCA is the dominant hospital chain in many U.S. markets, especially in the South and West, and exploits that monopoly power to charge more. According to a 2020 NNU study, in 2018 HCA owned over half (53) of the most expensive hospitals in the nation. Notably, one reason HCA hospitals are so expensive is that they needlessly institute “trauma” care for patients that don’t require such intensive care.

In 2024, HCA Healthcare paid its CEO almost $23.8 million.

HUMANA

BRANCH OF HEALTHCARE INDUSTRY: Insurance (with a network of primary care clinics)

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $5.5 billion

Humana, the nation's fourth biggest health insurer, dodged $5.5 billion in taxes over the first seven years of the Trump tax law. In the first year of the law (2018), Humana paid a federal tax rate of just 6.9% on over $2 billion profit. In that same year, the average American individual taxpayer paid an effective tax rate nearly double that (13.3%).

The company's shareholders received almost twice as much in average annual dividends in the seven years after the law as the four before. Humana has paid out almost $2.5 billion in dividends under the first Trump tax law.

Humana Medicare Advantage plans tied with Elevance for the highest number of prior authorization determinations per enrollee, indicating that Humana imposes prior authorization requirements more broadly than most other Medicare Advantage plans. As noted earlier, the American Medical Association (AMA) has significant concerns about prior authorization. The AMA's 2024 survey found that 93 percent of physicians reported that prior authorization led to delays in patients' access to necessary care, and 82 percent reported that prior authorization sometimes led patients to abandon recommended treatment. Notably, of the Humana prior authorization denials that were appealed, nearly 65 percent were overturned–indicating that many Humana prior authorization denials were improper, inappropriately delaying or denying beneficiaries care that they were entitled to receive.

Humana has been accused of using artificial intelligence (AI) to deny claims for post-acute care, such as therapy and skilled nursing facility care that often follows a hospital stay. The class action lawsuit alleges that Humana's AI tool directs Humana to prematurely stop covering care without considering an individual patient's needs.

In March 2025, Humana was among three companies named in a False Claims Act complaint filed by the Department of Justice (DOJ). Specifically, the DOJ alleged that Humana paid illegal kickbacks to brokers in exchange for steering desirable enrollees to its Medicare Advantage (MA) plans, while avoiding enrollment of Medicare beneficiaries with disabilities, who were perceived

as less profitable.

Like many Medicare Advantage insurers, Humana has come under scrutiny for extracting inflated payments from the U.S. government. In 2024, the Department of Health and Human Services Office of Inspector General (OIG) estimated that, based on an audit of selected diagnosis codes, Humana likely received at least $13.1 million in overpayments for 2017 and 2018. Specifically, the vast majority of diagnosis codes audited were not supported by the medical records and resulted in overpayments.

Humana paid CEO Jim Rechtin over $15.5 million in 2024, although he was only promoted to CEO in July 2024. Outgoing Humana CEO Bruce Broussard received over $12 million in total compensation for 2024, although he retired half way through 2024.

CIGNA

BRANCH OF HEALTHCARE INDUSTRY: Insurance (with PBM, plus specialty and care services)

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $2 billion

Cigna, the nation's eighth largest health insurer, saved $2 billion in taxes over the initial seven years of the first Trump tax law.

One of the biggest corporate giveaways in the Trump law was the more than half-off tax discount afforded the accumulated offshore profits of American corporations. Just before the Trump law was enacted, it was estimated that U.S. firms held $2.6 trillion of earnings offshore, on which they owed up to $750 billion in U.S. taxes at the then 35% corporate tax rate. Under the old law those taxes weren't due till the money was brought home.

The Trump tax law allowed American companies to bring those profits home and pay only a 15.5% rate on cash and cash equivalents (just 8% on less liquid forms of assets). Cigna saved an estimated $181 million in U.S. taxes on the $2.5 billion in profits it held offshore before the first Trump law.

> “ CIGNA SAVED AN ESTIMATED $181 MILLION IN U.S. TAXES ON THE $2.5 BILLION IT HELD OFFSHORE.

That law seems to have transformed Cigna’s dividend program from one of token payments to one of substantial payouts. The company’s relatively modest $10 million in total average annual dividends in the four years before the law ballooned into an annual average of $825 million in the seven post-law years.

Cigna offers Medicare Advantage, where prior authorization requirements are increasingly burdensome for patients and providers. In 2023, 86 percent of Cigna’s prior authorization denials that were appealed were overturned – indicating that many of Cigna’s prior authorization denials were improper and that beneficiaries’ medical treatment was unnecessarily delayed or denied.

Since 2018, Cigna has owned the company EviCore by Evernorth, which insurance companies hire to review prior authorization requests. ProPublica has dubbed this model the “denials for dollars business”: EviCore promises a sterling 3-1 return on investment to insurance companies that purchase its services through reduced spending on medical care. An extensive investigation by ProPublica uncovered EviCore salespeople boasting of increasing denials by 15%. Cigna itself also contracts with EviCore, and it has requested a plan that would send more cases to clinical review and therefore generate more denials.

Cigna also reportedly uses algorithms to allow its doctors to reject insurance claims on medical grounds without even opening the patient file. According to ProPublica’s investigation, Cigna doctors were able to deny over 300,000 claims in just two months by spending an average of just 1.2 seconds on each one. This appears to violate many state requirements for medical directors to review patient records in deciding whether to approve or deny claims.

Cigna has disputed this story, emphasizing that the review process involves “a simple sorting technology that has been used for more than a decade” and that any savings from lower medical costs benefit Cigna’s clients, such as employers, governments, and nonprofit organizations. “Our company does not profit by denying claims – period,” Cigna concluded.

In a study of CEO compensation at the largest health plans, Cigna ranked third, paying their CEO over $23.25 million in 2024.

UNIVERSAL HEALTH SERVICES

BRANCH OF HEALTHCARE INDUSTRY: Hospitals and behavioral health centers

7-YEAR SAVINGS FROM 2017 TRUMP-GOP TAX LAW: $463 million

The first Trump tax law saved Universal Health Services (UHS) almost $463 million in its initial seven years. The company's average annual stock buybacks tripled in value in the period after the law compared to the four years before it. At the same time, Universal Health Services has been repeatedly accused of overbilling and patient abuse.

In 2020, Universal Health Services, Inc. and UHS of Delaware paid $117 million to resolve allegations of billing for medically unnecessary inpatient behavioral health services and failing to provide adequate and appropriate services to patients admitted to UHS facilities. In particular, the government alleged that Universal Health Services and UHS of Delaware admitted patients for inpatient or residential treatment even though they did not require that level of care, failed to discharge appropriately admitted patients when they no longer required inpatient care, and improperly used physical and chemical restraints and seclusion on patients.

In 2024, the Senate Finance Committee released a report documenting widespread physical and sexual abuse at residential treatment facilities, highlighting problems at several Universal Health Services (UHS) facilities. Among the abuses documented were a staff member at one UHS facility pouring scalding water on a non-verbal 16-year-old with developmental disabilities, causing second- and third-degree burns. The report highlighted several instances of staff placing children in chokeholds and striking them in the head, as well as one child who "died of positional asphyxiation" after being placed in a restraint at a UHS facility. The report also detailed widespread sexual abuse at UHS facilities, perpetrated both by staff and by other youth.

Numerous lawsuits have alleged sexual abuse and improper commitments at UHS facilities. In 2024, an Illinois jury found that a UHS subsidiary's negligence was the proximate cause of the rape of a 13-year-old patient by another patient at the facility in 2020. Though the judge reduced the amount of punitive damages awarded by the jury, he declared: "The evidence was overwhelmingly against The Pavilion [the UHS subsidiary]" and emphasized that "this was not a close case on the issue of liability." The UHS subsidiary appealed, and the matter was ultimately settled out of court.

Also in 2024, a Virginia jury found that a Universal Health Service subsidiary was liable for inappropriate sexual contact during medical examinations. Although UHS was dismissed from that case during trial, it has disclosed that approximately 40 additional plaintiffs have pending claims relating to similar allegations. In addition, over 100 former minor patients filed a lawsuit against Universal Health Services in 2024, alleging sexual abuse at its behavioral health facilities in Illinois.

In 2025, a Universal Health Services psychiatric hospital in the District of Columbia–the Psychiatric Institute of Washington–was sued in federal court for a range of alleged abuses, including involuntary hospitalization and withholding of necessary treatment. The lead plaintiff in the class-action suit claimed she was involuntarily held by PIW and denied access to a phone, all on the uncorroborated allegations of her estranged husband. Separately, the District of Columbia government has announced increased oversight over this Universal Health Services facility, following a report from Disability Rights DC that documented multiple patient-on-patient assaults and the arrest of a staffer who allegedly sexually assaulted a minor patient.

In 2024, Universal Health Services paid its CEO over $15 million in compensation.

HOW PRIVATE EQUITY RUINS HEALTHCARE

The seven healthcare companies discussed so far in this study are all public corporations, so it's possible to estimate their tax savings from the 2017 Trump tax law based on the financial information they regularly provide to investors. Not so for the final healthcare provider discussed below, because it is privately owned–and until recently, by private equity investors.

Private equity is the pooling of money from institutions like pension funds and rich individuals for the purpose of buying public companies, operating them as private corporations for short periods–during which the owners drain money from the acquired companies–then selling at what's hoped to be a good profit.

Photo: David L. Ryan/Boston Globe

PROSPECT MEDICAL HOLDINGS

Prospect Medical Holdings (PMH) was taken off the public market 15 years ago by the private equity firm Leonard Green & Partners (LGP).

By the time LGP divested itself of Prospect in 2021, the chain–which has operated hospitals catering mostly to poor residents in several states, including California and Pennsylvania–was in bad financial shape. It eventually filed for bankruptcy in early 2025. One reason for the PMH's financial distress was the $658 million in mostly debt-funded

dividends LGP had extracted from it over its decade of ownership.

The 2017 Trump law did not change the tax treatment of dividends (or capital gains)–but that very omission was a boon to dividend recipients like the owners of LGP. That's because, especially at the levels paid out from Prospect, dividends are taxed at a significantly lower rate than income from wages. The top dividend tax rate is 23.8% (including a surcharge on higher income like this), whereas a salary of hundreds of millions of dollars would face a top marginal rate of 40.8% (including payroll taxes).

The last and biggest dividend payment from Prospect to its owner LGP, of $457 million, was made in 2018, the first year of the first Trump tax law, which left in place the tax advantage of investment income over wages. Had the Republican law (which claimed to be "tax reform") eliminated that tax advantage for investment income, the wealthy owners of LGP could potentially have owed $78 million more in taxes on that one big payout alone.

As the LGP partners were enjoying their tax savings, the patients in their PMH facilities were suffering from unsanitary conditions, supply shortages, insufficient staffing, shuttered departments and other defects that make hospitals dangerous. Bandages and IV materials were held by the supplier for lack of payment, ambulances couldn't refuel because the company credit cards were declined, and an ER doctor at a Prospect hospital in New Jersey died after being forced to use the same mask for four days at the height of the pandemic.

> "AS THE PARTNERS WERE ENJOYING TAX SAVINGS, THE PATIENTS WERE SUFFERING.

As of 2020, just before LGP dumped PMH, the hospital chain was receiving poor ratings for safety and service. The Centers for Medicare and Medicaid Services (CMS) that year gave most of Prospect's 16 hospitals a one- or two-star rating out of its five-star quality grading system, placing them in the bottom third of all hospitals.

In Delaware County, PA, PMH acquired the four-hospital Crozer Health System in 2016, promising to keep all of the hospitals open for at least 10 years. In the years that followed the acquisition, the hospitals were chronically understaffed and cited for multiple safety violations, and they all closed within 10 years. In 2022, Crozer announced that one hospital would be closing "temporarily" due to staffing issues, but the hospital never reopened for acute care. The Pennsylvania Department of Health shut down another hospital in 2022 because of understaffing. In 2025, PMH filed for bankruptcy and–despite an influx of $40 million from the state, the county, and other stakeholders to keep the remaining two hospitals open–closed the last of the Crozer hospitals and left more than 3,000 health care workers unemployed.

The Pennsylvania Attorney General sued PMH and LGP for mismanagement and "corporate looting," although the lawsuit is currently stayed due to the bankruptcy proceedings.

OTHER PRIVATE EQUITY HEALTHCARE INVESTMENTS

In addition to hospitals, private equity firms are also buying up other healthcare assets, including doctors's practices. As recently as 35 years ago, almost three-quarters of all doctors owned their own practices. Today, that percentage is reversed – about 78% of physicians are employed by hospitals or other corporate entities, including private-equity firms. This change has a big impact on the healthcare system. One study found that practices owned by private equity charged over 20% more for services than other practices.

CONCLUSIONS & SOLUTIONS

It's no coincidence that the same healthcare companies that have dodged the most in taxes because of the 2017 Trump tax law (and through loopholes that predate that law but which it failed to close) are also harming patients by jacking up prices and offering substandard care. Both behaviors reveal a lack of concern for community.

> "THE SAME HEALTHCARE COMPANIES THAT HAVE DODGED THE MOST IN TAXES ARE ALSO HARMING PATIENTS.

Whether strategically employing offshore subsidiaries; deducting more from their taxes than they declare to their investors for the same employee stock options; or joining with the general business community in pushing for a two-fifths cut in the corporate tax rate despite booming profits–these medical mega corporations are using the tax system to fatten their bottom lines.

At the same time, some of the most profitable healthcare entities show little regard for people's health. The most profitable insurance companies impose burdensome prior authorization requirements and deny coverage for legitimate claims and necessary procedures. The most profitable hospital chain puts patient safety at risk by understaffing and not maintaining their facilities. The most profitable behavioral health facility chain has allowed widespread physical and sexual abuse of patients, many of whom are children. In short, these corporations are harming ordinary people–or failing to prevent such harm–in order to boost their own profits.

We call on policymakers to act. Congress must close loopholes, end special tax breaks, and raise the corporate tax rate so that huge healthcare companies are paying a fairer share of tax. At the same time, Congress and regulators must ensure that hospitals, other healthcare facilities, and insurance companies place the health and safety of patients first.

With these reforms, we can build a healthcare system that truly serves patients and places people over profits.