The high prices paid to providers, particularly those in large, consolidated hospitals and health systems, are driving up health care costs for people with private health insurance.

- Prices are the primary driver of increased health care spending and insurance premiums among people with insurance coverage through their employer.

- Between 2018 and 2022, average health care prices increased 14% while utilization increased 4%. During the same period, the average price of inpatient patient hospital admissions increased by 20%.1

- Within health spending, hospital spending represents almost a third of overall spending.2 Put another way, for every three dollars spent on health care, one dollar goes towards hospitals.

- The prices that hospitals charge privately insured Americans for care are much higher than the prices paid in public programs, since private payers have less of an ability to constrain the prices charged by hospitals with substantial market power than government payers do. On average, hospitals charge privately insured patients more than 2.5 times what Medicare pays for the same service, with some hospitals charging over 5 times what Medicare would pay.3,4

- Certain physician specialties are also able to charge excessive prices. For example, anesthesiologists charge privately insured patients 3.5 times what Medicare would pay on average.5

- If the prices hospitals could charge were limited to 2 times what Medicare pays, it could reduce premiums for Americans with private insurance by $889 billion over the next decade.6

Consumers, patients, and employers ultimately bear the brunt of rising health care prices, as premiums and out-of-pocket costs rise and health care becomes less affordable.

- Over a quarter of covered workers are now enrolled in high deductible health plans and the average annual premium for an employer-sponsored family plan costs around $24,000.7

- Economists have found health care costs outpace wage growth.8 Since 2000, premiums and deductibles have risen 355% and 473% respectively, while wages have risen 178%.9

- Rising prices depress wages as money that would have gone to higher wages has instead gone toward the cost of providing health benefits.10 One analysis found that workers across the United States could lose between $18,000 and $25,000 in wages over the next decade because of rising premiums.11

- Offering health care benefits is a core value for many employers, but excessively high prices force employers to pass a greater share of health insurance costs (premiums and out-of-pocket costs) onto employees and their families. The availability of high deductible health plans in the commercial market has grown from 33% in 2014 to 51% in 2023.12

- Employers also pay more due to rising health care prices, which can affect their ability to offer employee benefits. 90% of large employers say that rising health care costs will become unsustainable in the next five to 10 years if costs are not lowered.13
High and rising prices are the result of decades of unchecked consolidation in the health care sector. As large hospitals and health systems consolidate, they gain more market power to charge even higher prices and use anticompetitive business tactics to further limit competition.

- Nearly 90% of health care provider markets are highly concentrated, according to U.S. Federal Trade Commission (FTC) standards. As of 2021, 13 health systems accounted for 25% of all US hospital beds.
- Numerous studies have documented an increase in commercial health care prices ranging from 6% to as high as 65% following hospital mergers. Not only do merged hospitals increase their prices — their nearby competitors raise their prices as well. In one study, neighboring hospitals increased prices by 8%.
- When hospitals acquire a physician practice, the price increases as well. When a physician’s office is acquired by a hospital system, the prices increase by more than 14%.
- Cross market mergers, or mergers between providers in different geographic markets, are becoming increasingly common with more than half of all mergers during 2010-2019 qualifying as cross-market. Evidence shows that prices increase almost 13% in the six years following an acquisition, without quality improvements.
- Certain actors are increasingly taking advantage of regulatory loopholes and market failures to increase their revenues. For example, private equity (PE) firms increase consolidation in some health care markets and increase prices. Evidence indicates that anesthesiologists employed by PE-owned companies had prices that were more than 2.5 times higher than non-PE employed anesthesiologists.

Doctors have justified consolidation by saying it improves quality, but the evidence shows that consolidation does not result in higher quality care and likely reduces choice and access.

- Although provider consolidation results in price increases, it does not result in associated gains in quality. Most studies have shown little to no effect on quality, with some studies even showing that quality decreased.
- Consolidated health care markets have been linked to worse health outcomes by some studies. One study conducted by the FTC found that when cardiology markets are concentrated, cardiology patients are more likely to have heart attacks, visit the emergency room, be readmitted to the hospital or die.
- Health care consolidation can limit access to care in rural areas. Evidence suggests that as large systems acquire rural hospitals, they reduce key services such as primary care, obstetrics, neonatal, surgery, and imaging. This can in turn increase wait times and reduce access for patients.

The high cost of health care is linked to medical debt and poor outcomes.

- 100M Americans are saddled with medical debt. 4 in 10 adults with employer-sponsored health insurance report having problems affording their medical bills.
- Despite major expansions in health insurance coverage in the last decade, nearly 1 in 5 adults in the U.S. owes medical debt and that burden is not equally distributed: Black Americans, individuals with disabilities, and those living in the South are most likely to face significant medical debt.
- High prices and the fear of medical debt are prompting more people to put off medical care; more than 1 in 4 adults in the U.S. reported cost-related reasons for delaying or forgoing care.
The excessive prices charged to patients are often set arbitrarily, are irrationally high, and have little to do with the cost of providing care.

- Prices vary widely within a given market for the same service. In El Paso, Texas, depending on the physician you visit, prices for the same blood test ranged from $144 to $952. Prices also vary substantially across markets – that same blood test is only $25 in Portland, Oregon.  

- In Boston, the price of a vaginal delivery can be $14,615 higher or lower depending on the hospital. One study found prices vary more within a given health system and within a given state than across systems and states.

While physicians argue they must charge high prices to privately insured patients to compensate for lower Medicare/Medicaid reimbursements, economic evidence overwhelmingly shows that cost-shifting does not occur.

- Some studies have even found that hospitals lower private insurance prices in response to cuts in government payment rates, which is the opposite of what the cost shifting theory predicts.

- On average, hospital prices in the private insurance market, which are on average 224% of what Medicare would have paid, are about 150% of hospital costs.

- Medicare Payment Advisory Commission (MedPAC) analyses have found that costs rise with prices. When hospitals receive high commercial payments, they have higher costs per patient because they have less incentive to operate efficiently.

- Put another way, some of the wealthiest hospitals in the country appear to have the lowest Medicare margins because they have no incentive to be efficient.


