



Bleeding Americans Dry: The Role of Big Hospital Corporations in Driving Our Nation's Health Care Affordability and Quality Crisis

September 2022

Hospitals are essential to the U.S. health care system and to the communities they serve. They provide lifesaving services for acute and complex conditions. They also provide critical training for doctors, nurses and other health care providers, and are an important source of jobs for our nation's workers. But the role of hospitals in our economy has shifted in disturbing and destructive ways over the last 60 years.¹ What were once local charitable institutions built to serve the community have now become large corporate entities focused on maximizing revenue rather than improving health.² Fundamentally, the business interests of the hospital sector are not aligned with the interests of the patients they serve. These misaligned incentives are a fundamental driver of our nation's health care cost and quality crisis.

There is long-standing evidence that the excessive cost of health care in the United States relative to peer countries is driven by Americans paying much higher prices than any other country rather than receiving better health care.³ These high prices have gotten much worse in recent years because of health care industry consolidation — particularly among hospitals — that has eliminated healthy competition and led to monopolistic pricing. Consolidation has taken place without meaningful regulatory oversight or effective intervention.⁴ Importantly, these higher prices result in more than \$240 billion of waste annually and account for more than one-quarter of total wasteful spending — \$900 billion — that is generated in the U.S. health care system on an annual basis.⁵ This wasteful spending resulting from high prices

ultimately comes directly out of workers' paychecks (typically as annual increases in employer-sponsored health insurance premiums and cost sharing) and becomes profits or margins for large health care corporations.⁶ The rising cost of American health care is crippling our nation's families forcing more than 100 million people into health care debt across the nation with 63% having to cut spending on food, clothing and other basic necessities because of this debt.⁷

What makes the extraordinarily high cost of our hospitals particularly egregious is how little that money buys us. The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries. One of the best indicators for health outcomes is amenable mortality — the measure of treatable and preventable deaths that could be avoided with timely and effective interventions. The U.S. fares worse than most other industrialized countries and is tied with Estonia and Montenegro with a score of 81.⁸ In other words, despite the fact that hospital and physician care account for half of U.S. health care spending,⁹ the system fails to provide timely and effective interventions to save Americans' lives. Given that hospitals are on the front lines of providing care to our nation's families, it is even more jarring that health care acquired infections (HCAIs) are one of the top 10 causes of death in the U.S., with more than 72,000 patients dying each year, despite billions of federal and state dollars being spent to reduce hospital infections.¹⁰ Our health care system also has worse health outcomes than other advanced countries as evidenced by having the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.^{11,12} These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.¹³ Our current system is simply not acceptable. We can do better.

U.S. Health Care Industry Consolidation Has Led to



**UNCONTROLLED PRICE
HIKES THAT FAMILIES
ARE LEFT TO BEAR**



**WORSE HEALTH
OUTCOMES**

Example

72,000 DEATHS
PER YEAR FROM
HOSPITAL ACQUIRED
INFECTIONS



**(COMPARED TO OTHER
ADVANCED COUNTRIES)**

Examples

**HIGHEST RATES
OF INFANT
MORTALITY**

**HIGH RATES OF
PREVENTABLE
DEATHS FROM
HEALTH SYSTEMS
FAILING TO
PROVIDE TIMELY &
EFFECTIVE CARE**

The business model of big hospital corporations is in conflict with the interests of our nation's families

We have all watched in our communities as hospitals have become health systems, and those health systems have been bought by large health care corporations. These large health care corporations have destroyed competition in our health care sector, and hospitals are dramatically increasing their prices year after year.^{14, 15} The core business model of health care corporations is to generate high volumes of tests and procedures through fee-for-service payment, the predominant payment model in the U.S. health care system, and to generate the highest possible fees (price) for each service.¹⁶ A key strategy in hospitals' current business model is to generate profit by buying up other hospitals and doctor's offices to become large corporate health care systems that maximize service volumes and increase health care prices. The financial incentives of the hospital business model — to buy up local competition so that the hospital can engage in anticompetitive behavior, price gouging and to increase volume on fee-for-service payment — is costly, wasteful and bad for our communities' health.^{17, 18, 19} The imperative to generate lots of the priciest hospital services is in direct conflict with ensuring that consumers and patients have the best health and the affordable health care they deserve.

This “revenue above all” business model has been in full swing over the last 30 years. There has been dramatic consolidation in the health care sector, which has resulted in most geographic areas across the country being dominated by large corporate health care systems that can unscrupulously drive up health care prices.^{20, 21, 22} Since 2010, more than 1,600 hospitals have merged, and the number of doctor's offices being bought by health care monopolies has increased dramatically, with more than half of all physicians now being employed by hospital-owned practices.^{23, 24, 25, 26, 27} This growth in big health care corporations is the primary cause of the high and variable health care prices that are driving our nation's affordability crisis. Since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.^{28, 29, 30,} Unfortunately, these higher prices have not improved our nation's health.^{31, 32, 33}

Since 2015, U.S. Hospital Prices Have

Increased by as much as **31%**

Grown **MORE THAN 4X** FASTER than workers' paychecks.

High and variable hospital prices

The prices that health care systems charge for medical tests and procedures should reflect their cost, efficacy and quality, not whatever hospitals can get away with charging for those services. Ultimately, hospitals should be allowed to generate revenue because they are providing the best care and have the best health outcomes for the patients they serve. Yet this is not how the hospital business model currently operates. The U.S. spent nearly 20% of its gross domestic product on health care in 2020, far exceeding spending on health care by any other industrialized country.³⁴ These high costs have occurred despite lower hospital utilization and are largely due to price increases, which are the result of industry consolidation and the expansion of big health care corporations described above.^{35, 36}

Consider how health care prices in the U.S. compare with other wealthy nations, which enjoy much better health outcomes. For example, the average price of a hospital-based MRI in the U.S. is \$1,475.³⁷ That same scan costs \$503 in Switzerland and \$215 in Australia.³⁸ Or take the price of coronary bypass surgery. Despite the fact that the U.S. performs fewer bypass surgeries compared with other industrialized countries, the average price of coronary bypass surgery in the U.S. is \$78,318. That same procedure costs \$28,888 in Australia and \$24,059 in the United Kingdom.³⁹ These higher prices for an identical procedure are the main reason that U.S. per capita health care spending is so much higher than that in other countries and has increased so quickly.

The High Price of U.S. Health Care Compared With Other Wealthy Nations

Average Price for an MRI



\$1,475
UNITED STATES



\$503
SWITZERLAND



\$215
AUSTRALIA

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THE STORY OF SUTTER HEALTH: NORTHERN CALIFORNIA'S DOMINANT HEALTH SYSTEM

Over the course of several decades, the not-for-profit Sutter Health system consolidated and bought its way into becoming a major health care system with dominant control in the northern part of California. The system includes 24 acute care hospitals, 36 ambulatory surgery centers, and 16 cardiac and cancer centers. As Sutter gained market power, the health system engaged in hard-nosed business practices that had the effect of limiting its competition, including “all or nothing” contract requirements, which require an insurer to contract with all health system’s facilities or none (driving up volume and price), and opaque pricing that resulted in prices in Northern California growing four times faster than prices across the rest of the state between 2004 and 2013.⁴⁰ In fact, hospital prices in Northern California are some of the highest in the country and substantially higher than in neighboring Southern California.⁴¹

As a result, Sutter was sued for engaging in anti-competitive business practices, including two major recent antitrust lawsuits: one in federal court and one in state court. The first, *Sidibe v. Sutter Health*, was a class-action lawsuit filed in 2012 in federal court in San Francisco.⁴² Before the case was tried in early 2022, the district court dismissed it twice, but both dismissals were then reversed on appeal.⁴³ The second case, *UEBT v. Sutter Health*, was a class-action lawsuit filed in 2014 in state court in San Francisco. Additionally, *The People of California v. Sutter Health* was filed by then-Attorney General Xavier Becerra in 2018 in state court and was then consolidated with the UEBT case.

At a high level, these cases made similar allegations: Sutter had gained unfair market advantage and was engaging in anti-competitive practices to abusively set and increase prices in contract negotiations.^{44, 45, 46} Facing two lawsuits, one backed by the state attorney general (a very rare occurrence), Sutter settled the consolidated state case with UEBT and the attorney general in 2019, agreeing to compensate plaintiffs in a cash settlement of \$575 million and to change its anti-competitive and monopolistic business practices.⁴⁷ This was a major victory for consumers and an important demonstration of the anti-competitive and monopolistic behavior of large hospital systems and how that behavior hurts access to care. Sutter won the second case, the federal case, which was focused more narrowly on the legality of the contract terms as opposed to the state case that focused more broadly on the impact of these practices over time and the anti-consumer effect.^{48, 49} The plaintiffs in the federal case have filed an appeal.⁵⁰ The outcomes of these two landmark cases will now be used in antitrust case law moving forward.



Pricing abuses in health care, including high hospital prices, cost American workers an estimated \$240 billion in wasteful spending alone each year.

High hospital prices increase costs of employer-sponsored health insurance

Most Americans of working age receive health care coverage through their employers and through private insurance.⁵¹ Unfortunately, private health insurance companies have failed to negotiate a fair price for health care services, and these health plans often have their own conflict of interest because their long-term margins are directly proportional to the total amount of money collected for health care services.⁵² Each year price gouging by hospitals continues to be allowed by insurers and policymakers, and families and individuals then must pay more in health insurance premiums and cost sharing, which come directly out of their paychecks. Premium increases in particular are often “hidden” from workers because premiums are automatically deducted from their paychecks, and workers almost never know the total cost of health insurance. In the end, pricing abuses in health care, including high hospital prices, cost American workers an estimated \$240 billion in wasteful spending alone each year.⁵³ As a result, workers see smaller or no increases in their salaries, and it becomes more difficult for them to afford where they live, pay their day-to-day expenses, send their children to college and be able to retire.^{54, 55, 56}

Study after study shows that commercial health care prices — prices negotiated between hospitals and insurers — are growing much faster than Medicare payments, which involve a federal administrative price-setting process. In 2020, privately insured consumers and employers paid on average nearly two and a half times what Medicare would have paid for the same hospital inpatient and outpatient services.^{57, 58, 59} In some states, employers and private insurance plans pay on average nearly three and a half times what Medicare pays for hospital inpatient and outpatient services.⁶⁰

Health care prices are driven by market power abuses. For example, commercial insurance prices for hospital or physician services in more monopolistic markets like Florida, South Carolina, Tennessee

Price Range for an MRI

\$839 – \$4,200

*Price range for an MRI in a single hospital system
(Massachusetts General Hospital, Boston, Massachusetts)*

Health Care Prices Are Driven by Market Power Abuses

and West Virginia cost almost twice as much as the exact same services in more competitive markets in Arkansas, Michigan and Rhode Island.⁶¹ The average price for a knee replacement for a patient in Tucson, Arizona, is \$21,976, while the same procedure would cost about \$60,000 in Sacramento, California.⁶² Similarly, prices for identical clinical lab tests such as blood tests are three times higher in hospital outpatient departments than the prices of those same lab tests in a physician office and independent laboratory.⁶³

An even more dramatic indicator of how market power drives hospital pricing is that prices in a single hospital system vary significantly across insurers. For example, the price of an MRI at Massachusetts General Hospital in Boston, Massachusetts, ranged from \$839 to \$4,200 depending on the insurance carrier.⁶⁴ These unchecked increases in what health care corporations charge insurance plans result in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance through their employer or directly from a health plan.^{65, 66}

Nonprofit tax-exempt status

Unfortunately, the abuses carried out by these medical monopolies include many “nonprofit” hospital corporations. Under federal tax law, nonprofit hospital corporations are granted tax-exempt status premised on the assumption that they provide a community benefit and a public good.^{67, 68} By definition, tax-exempt hospital corporations are prohibited from generating and distributing profits. In exchange, tax-exempt status protects billions of dollars in revenue for these institutions.⁶⁹ While the Affordable Care Act included new requirements that tax-exempt hospitals report on community need and limit some charges and billing, many nonprofit hospitals continue to charge exorbitant prices for their services, put families’ unpaid medical bills in collections and invest in new services

More than 80% of nonprofit hospitals and health care systems spend less on charity care and community investment than the amount they receive through their tax breaks as nonprofit institutions.

and technologies that expand their revenue in lieu of meeting the needs of their communities.⁷⁰

⁷¹ More than 80% of nonprofit hospitals and health care systems spend less on charity care and community investment than the amount they receive through their tax breaks as nonprofit institutions — referred to as the “fair share deficit.”⁷² In 2019, the fair share deficit for those hospital systems totaled more than \$18 billion.⁷³

When hospitals first received tax-exempt status, they were not the large medical monopolies and revenue centers that they have become today. Historically, community hospitals provided free care to people living in poverty and were primarily funded by donations and staffed with volunteers. But today, these nonprofit hospitals rake in substantial profits. In 2016, seven of the 10 most “profitable” hospital systems were nonprofits, each earning more than \$163 million in operating margins from patient care services.⁷⁴ Moreover, many of these health systems received hundreds of millions of dollars in COVID-19 relief payments from the CARES Act and ended 2021 with record high incomes and operating margins despite the COVID-19 pandemic.^{75,76} Importantly, many nonprofit hospitals funnel their excess margins into salaries, new equipment, new buildings and lobbying rather than improving the health of their community and providing affordable care. This unchecked revenue also grants hospitals significant political power to preserve their current business model. In 2018, hospitals and nursing homes spent over \$100 million on lobbying activities and spent about \$30 million on campaign contributions.⁷⁷

High salaries of hospital CEOs

Nowhere is excess in hospital payments more evident than the salaries paid to hospitals’ top executives, in both nonprofit and for-profit hospital sectors.

While far too many Americans are making impossible decisions between seeking medical care and feeding their family, the CEOs of many large hospital corporations are raking in millions of dollars in compensation every year.⁷⁸ In 2019, the Chief Executive Officer and President of nonprofit Banner Health earned \$21.6 million.⁷⁹ The health care industry has now become one of the highest-paying nonprofit industries in the country.⁸⁰ In 2018, eight of the 10 highest-paid CEOs at nonprofits were from large health care corporations.⁸¹

While Families Must Decide Whether to Eat or Seek Medical Care, Large Hospital Corporation CEOs’ Paychecks Have Skyrocketed

President of nonprofit Banner Health, 2017 Salary

\$21.6 MILLION

CEO of HCA Healthcare, 2020 Salary

OVER \$30 MILLION

The ability of payment reform to fulfill its promise to transform health care payment and delivery hinges on moving away from fee-for-service (FFS) economics and creating new financial incentives that reward providers for keeping patients healthy and hold providers accountable for the cost of care.

To make matters worse, for-profit companies have taken on a larger role in the hospital industry. The CEOs of for-profit health care systems are earning even more than their nonprofit counterparts. These higher earnings are driven by significant profits and revenue amassed from buying up the competition in communities across the country. For example, Samuel Hazen, the CEO of HCA Healthcare, a 185-hospital system based in Nashville, Tennessee, brought in over \$30 million in earnings in 2020, while the hospital system ended 2020 with a profit of \$3.8 billion on revenue of \$51.5 billion.^{82,83} These billions of dollars in hospital profits were accrued while nearly half of Americans had to forgo medical care due to the costs of care and a third had health care costs that interfered with their ability to secure basic needs like food and housing.⁸⁴ Moreover, as the CEO salaries of these medical monopolies increase, the wages of the health care workers in their hospitals go down. For example, wages for nurse and pharmacy workers have been shown to decrease by nearly 7% after mergers of these large health care corporations.⁸⁵

In the end, these outrageous salaries are factored into hospitals' costs and used as a justification for pricing abuses — one of the important ways that hospitals can “build” to the abusive prices they want to charge. This is a national scandal.

Exaggerated value-based payment claims by hospital corporations

While hospital corporations have been price gouging and paying their CEOs tens of millions of dollars, many of these same hospital corporations and other actors in the health care sector have been aggressively lobbying policymakers and patients about their movement away from fee-for-service and toward important new value-based payment models.⁸⁶

The ability of payment reform to fulfill its promise to transform health care payment and delivery hinges on moving away from fee-for-service (FFS) economics and creating new financial incentives that reward providers for keeping patients healthy and hold providers accountable for the cost of care. Importantly, **non-FFS-based payment reform does hold the promise** of effectively addressing broken hospital incentives that drive unaffordable, low-quality and inequitable care.

However, most hospital claims of engaging in value-based payment are exaggerated or even misleading. Across the nation, the vast majority of hospital payment arrangements are still anchored in fee-for-service economics.⁸⁷ For example, over 1,000 hospitals participating in Medicare's voluntary bundled payment program continue to receive fee-for-service payments under this

model.⁸⁸ Even more troubling, providers that engage in bundling often aggressively increase volume both in the Medicare and private sectors (for example, putting up billboards in their communities to advertise newly bundled knee replacement services) and have been able to easily “align” with doctors in the bundle and capture more and more market share.^{89,90,91} Another example of faux value efforts by the health care sector can be pay-for-performance (P4P) efforts. These types of value-based payment initiatives are heavily anchored in FFS payment and often tie bonus or penalty payments to clinical process measures rather than health outcome measures. Consequently, many P4P programs do little to nothing to reorient financial incentives away from FFS and produce mixed results on improving quality or affordability, despite claims about value.^{92,93} In addition, several studies have shown that P4P actually reduces access to care for socioeconomically disadvantaged populations because it incentivizes providers to avoid treating low-income patients who may have unique barriers to achieving improvements in their health.⁹⁴ Yet a significant portion of value-based payment efforts are in these types of FFS models.⁹⁵

Further, current estimates indicate that 6.7% of all health care services are flowing through truly redesigned, non-FFS economic incentives that drive toward better care, lower costs and healthier patients.⁹⁶ Moreover, only 7% of hospitals have made the switch to population-based payment models or integrated delivery systems.^{97,98} As a result, many “value” claims are mostly a spin. These claims about value allow the health care sector to abuse a monopolistic or quasi-monopolistic bargaining position and demand outrageous prices by aligning with doctors for referrals and driving up the volume of tests and procedures. These cynical value claims also distract the public from the pricing abuses that drive revenues.⁹⁹

In the end, despite the promise of payment reform and all the spin about value by the health care sector over the last 10 years, American hospitals continue to buy other hospitals and doctor's offices to increase prices and increase the volume of high-margin services, all at the expense of the health and economic security of our nation's families.



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Key solutions are underway to rein in pricing and quality abuses

American families should not be struggling to pay skyrocketing health care costs while health care corporations and CEOs extort skyrocketing profits, salaries and bonuses. It is past time to implement policy changes that will make the health care sector more competitive, make health care more affordable and allow our nation's families to access the health and health care they deserve. Because health care operates through federal, state and local systems, policy solutions must be implemented in the U.S. Congress, the federal administration, state capitols and by governors.

Reining in hospital prices and fixing the broken financial incentives that allow hospitals to drive unaffordable care will require multipronged policy solutions that tackle different sides of the problem: the fee-for-service pricing abuses as well as the underlying financial incentives that are at odds with the interests of patients and families. In the short term, policymakers should focus on implementing policies that rein in abusive health care prices, making health care more affordable. In the intermediate to long term, policymakers should focus on redesigning the economic incentives of the health care sector to be aligned with consumers and families. Congress, state governments and the federal Centers for Medicare & Medicaid Services should work together to reorient health care payment and delivery to the goal that we all have — improved health care for ourselves and our families that is affordable and economically sustainable.

For example, policymakers will need to pursue price transparency polices that work to unveil the underlying price of health care services, which has been hidden as proprietary information in contracts between providers and insurers for far too long. Policymakers will also need to pursue solutions that block hospitals from taking actions that reduce competition in health care markets and result in higher health care prices and premiums, more narrow provider networks and restricted data flow. Other policy solutions will need to focus on challenging hospitals' nonprofit status to ensure these entities are not allowed to make undue revenue while the communities they serve have poor health and are unable to afford care. Policymakers should address abusive hospital pricing by setting hospitals on a "global budget" and leveraging health care cost containment commissions to ensure hospitals are being held accountable for reducing costs while improving population health outcomes.

We must build the consumer movement around these policy solutions to ensure that consumers, employers, workers, health equity leaders and others are coming together as a counterweight to the entrenched business interests and political influence of the hospital industry.

The good news is that elements of these approaches are already underway in Congress and the federal administration as well as in state capitols. Now we must build the consumer movement around these policy solutions to ensure that consumers, employers, workers, health equity leaders and others are coming together as a counterweight to the entrenched business interests and political influence of the hospital industry. Examples of current policy solutions underway include:

Reining in abusive prices and increasing competition to lower health care costs

- » Passage of the No Surprises Act in 2020. This law implemented a national ban to protect consumers against the practice known as surprise billing. Surprise medical bills are an important example of the ways large health care corporations engage in abusive pricing practices that increase their profit margins while leaving consumers with unexpected medical bills.
- » Prohibition of “gag” clauses passed through the Consolidated Appropriations Act of 2021. Gag clauses were often used as a key tactic by large health care corporations in contract negotiations with health plans to prevent consumers and other payers from seeing doctors’ cost and quality data.
- » Anti-competitive behavior bans. There are additional national efforts to ban other types of anti-competitive behavior like “all or nothing” clauses and “anti-steering” or “anti-tiering” clauses in contracts between large health care corporations and health plans through the 2019 Lower Health Care Costs Act passed by the U.S. Senate Health, Education, Labor and Pensions Committee.
- » Expansion of site-neutral payments. Through passage of the 2015 Consolidated Appropriations Act and subsequent implementation by the Centers for Medicare & Medicaid Services through the annual Hospital Outpatient Prospective Payment System rule, equalizing payments across sites of services has helped to correct long-standing broken financial incentives that allow outpatient hospitals and facilities to receive higher payment for delivering the same services that could be safely performed in a physician’s office.
- » State cost and affordability boards. A growing number of states are either implementing health care cost and affordability boards or working to pass legislation to establish them. There are various ways to structure affordability boards, but in general these entities establish statewide health care cost targets and analyze market trends in an effort to reduce health care costs and make care more affordable for consumers. Currently, Maryland, Massachusetts and Oregon have some form of affordability board or state health care cost growth targets. California is the latest state to establish an affordability board and includes the strongest enforcement mechanisms to slow state cost growth.¹⁰⁰ Connecticut, Minnesota and Rhode Island are considering legislation on different forms of affordability boards.¹⁰¹

- » Global hospital budgets. All-payer global hospital budgets are an alternative payment model used to control hospital costs. Under this model, hospitals are paid a prospective amount for all inpatient and outpatient services provided for a patient population and are held accountable for the total cost of care and population health outcomes. Both Maryland and Pennsylvania operate global hospital budget models.^{102, 103}

Increasing price and quality transparency to create a more efficient, fair and equitable health care system

- » All-payer claims databases (APCDs). APCDs are a critical tool to increase price, cost and quality transparency at the state and national level, and they are an important catalyst for the transformational change needed to drive high-value care in health care markets while lowering consumer costs. Nearly half of states have set up some kind of APCD, with 17 states having mandatory APCD reporting and seven states having voluntary APCD reporting. Another seven states are currently developing APCDs.¹⁰⁴ There have also been efforts to pass federal legislation to establish a national APCD through the 2019 Lower Health Care Costs Act, which passed the Senate Health, Education, Labor and Pensions Committee.
- » Hospital price transparency regulation. This regulation requires all hospitals to disclose on their websites the following: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges, as well as a consumer-friendly display for 300 “shoppable” services.¹⁰⁵ Several states are now working to pass legislation to codify the federal regulation into state law. Both Colorado¹⁰⁶ and Virginia¹⁰⁷ have now passed legislation to strengthen state oversight and enforcement of the hospital price transparency regulation.
- » Transparency in coverage regulation. This regulation requires group health plans and insurers in the individual and group markets to disclose cost-sharing estimates to consumers and to publicly release negotiated rates for in-network providers, out-of-network allowed amounts and billed charges.¹⁰⁸ The rule was finalized in 2020 and went into effect in July 2022.
- » Both the hospital price transparency and transparency in coverage regulations mark an important step forward in unveiling the underlying prices of health care to ensure that consumers, workers and employers are able to make informed decisions about the cost of health care and that the system is centered on delivering high-value care.



It is time to act if we are truly going to ensure the health care system serves the needs of our nation's families.

Conclusion

There are so many hardworking doctors, nurses, health care professionals and other front-line workers employed by large health care corporations. So many have committed their life's work to improving the health of our nation. At the same time, they are working for hospital corporations whose business interests are in direct conflict with the health and financial well-being of families across the nation. Because of the way the hospital business model is structured, the lives and financial security of the American people hang in the balance. Americans have worse health outcomes than many other industrialized countries, yet we continue to pay outrageous and ever-escalating health care prices. With each year that passes, hospital corporations consolidate, charge higher prices, consume more of our nation's economic activity and increase their political power.

Given the entrenched interests of hospital corporations to maintain the status quo, it will require a consumer-driven movement to make needed policy changes. It is time to act if we are truly going to ensure the health care system serves the needs of our nation's families.

Endnotes

- ¹ Barbra Mann Wall, “History of Hospitals,” *Nursing, History and Health Care*, University of Pennsylvania, n.d., <https://www.nursing.upenn.edu/nhnc/nurses-institutions-caring/history-of-hospitals/>.
- ² Wall, “History of Hospitals.”
- ³ Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, “It’s Still the Prices, Stupid: Why the US Spends So Much on Health Care, and A Tribute to Uwe Reinhardt,” *Health Affairs* 38, no. 1 (January 2019): 87–95, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144>.
- ⁴ Anderson, Hussey, and Petrosyan, “It’s Still the Prices, Stupid.”
- ⁵ William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, “Waste in the US Health Care System: Estimated Costs and Potential for Savings,” *JAMA* 322, no. 15 (2019): 1501–1509, <https://jamanetwork.com/journals/jama/article-abstract/2752664>.
- ⁶ David I. Auerbach and Arthur L. Kellerman, “A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family,” *Health Affairs* 30, no. 9 (September 2011), https://www.rand.org/pubs/external_publications/EP201100172.html.
- ⁷ Naomi N. Levey, “100 Million People in America are Saddled with Health Care Debt,” *Kaiser Health News*, June 16, 2022, <https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/>.
- ⁸ American Association for the Advancement of Science (AAAS), “First-Ever Global Study Finds Massive Health Care Inequity,” *EurekaAlert!*, May 18, 2017, <https://www.eurekaalert.org/news-releases/823133>.
- ⁹ Nisha Kurani et al., “How Has U.S. Spending on Healthcare Changed Over Time?” Peterson-KFF Health System Tracker, February 25, 2022, <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Average%20annual%20growth%20rate%20of%20GDP%20per%20capita%20and%20total%20national%20health%20spending%20per%20capita,%201970%20-%202020>.
- ¹⁰ “Healthcare-Associated Infections (HAIs),” Centers for Disease Control and Prevention, last reviewed October 27, 2021, <https://www.cdc.gov/hai/data/portal/index.html>.
- ¹¹ Rabah Kamal, Julie Hudman, and Daniel McDermott, “What Do We Know About Infant Mortality in the U.S. and Comparable Countries?” Peterson-KFF Health System Tracker, October 18, 2019, <https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries>.
- ¹² Jared Ortaliza, Giorlando Ramirez, Venkatesh Satheeskumar, and Krutika Amin, “How does U.S. life expectancy compare to other countries?” Peterson-KFF Health System Tracker, September 28, 2021, <https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/>.
- ¹³ “Racism and Health,” Centers for Disease Control and Prevention, last reviewed November 24, 2021, <https://www.cdc.gov/healthequity/racism-disparities/index.html>.
- ¹⁴ Martin Gaynor, *What to Do About Health-Care Markets? Policies to Make Health-Care Markets Work* (Washington, DC: The Hamilton Project, March 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf.
- ¹⁵ Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States* (Washington, DC: Urban Institute, January 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.
- ¹⁶ Emily Sokol, “Healthcare Reimbursement Still Largely Fee-for-Service Driven,” RevCycle Intelligence, March 26, 2020, <https://revcycleintelligence.com/news/healthcare-reimbursement-still-largely-fee-for-service-driven>.
- ¹⁷ Robert A. Berenson et al., *Market Consolidation and High Prices*.

- ¹⁸ 2020 Health Care Cost and Utilization Report (Health Care Cost Institute, May 2022), https://healthcostinstitute.org/images/pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf.
- ¹⁹ Heather Lyu et al., “Overtreatment in the United States,” PLOS ONE, September 6, 2017, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970#pone.0181970f>.
- ²⁰ Jaime S. King et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons From Five States* (Source on Healthcare Price and Competition and Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California Berkeley School of Public Health, June 2020), <https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/>; Martin Gaynor, Kate Ho, and Robert J. Town, “The Industrial Organization of Health-Care Markets,” *Journal of Economic Literature* 53, no. 2 (June 2015): 235–284.
- ²¹ Brent D. Fulton, “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses,” *Health Affairs* 36, no. 9 (September 2017): 1530–1538, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0556>.
- ²² Robert A. Berenson et al., *Market Consolidation and High Prices*.
- ²³ “Chart 2.9: Announced Hospital Mergers and Acquisitions, 2005–2017,” TrendWatch Chartbook 2018: Trends Affecting Hospitals and Health Systems (Washington, DC: American Hospital Association, 2018), <https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf>.
- ²⁴ Martin Gaynor, “Examining the Impact of Health Care Consolidation,” statement before the U.S. House Committee on Energy and Commerce Oversight and Investigations Subcommittee, Washington, D.C., February 14, 2018.
- ²⁵ *2018 M&A in Review: A New Healthcare Landscape Takes Shape* (Chicago: Kaufman, Hall & Associates LLC, 2019), <https://www.kaufmanhall.com/sites/default/files/documents/2019-01/2018-merger-acquisition-year-in-review-kaufman-hall.pdf>.
- ²⁶ “Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment, 2012-2018,” Physicians Advocacy Institute (PAI), February 2019, <http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-1>.
- ²⁷ Shruthi Venkatesh, “The Impact of Hospital Acquisition on Physician Referrals” (unpublished manuscript), November 2019, <https://shruthi-venkatesh.github.io/publication/working-paper-2/>.
- ²⁸ Kurani et al., “U.S. Spending on Healthcare.”
- ²⁹ Drew DeSilver, “For Most U.S. Workers, Real Wages Have Barely Budged in Decades,” Pew Research Center, August 7, 2018, <https://www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades/>.
- ³⁰ Health Care Cost Institute, *Cost and Utilization Report*.
- ³¹ Robert A. Berenson et al., *Market Consolidation and High Prices*.
- ³² Jeff Goldsmith et al., *Integrated Delivery Networks: In Search of Benefits and Market Effects* (Washington, DC: National Academy of Social Insurance, February 2015), <https://www.nasi.org/research/2015/integrated-delivery-networks-search-benefits-market-effects>.
- ³³ Thomas Koch, Brett Wendling, and Nathan E. Wilson, “Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries,” *Health Services Research* 53, no. 5 (January 2018): 3549–3568, <https://doi.org/10.1111/1475-6773.12825>.
- ³⁴ Emma Wager, Jared Ortaliza, and Cynthia Cox, “How Does Health Spending in the U.S. Compare to Other Countries?” Peterson-KFF Health System Tracker, January 21, 2022, [https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries-2/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202020%20\(U.S.%20dollars,%20PPP%20adjusted\)](https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries-2/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202020%20(U.S.%20dollars,%20PPP%20adjusted)).

- ³⁵ Health Care Cost Institute, *Cost and Utilization Report*.
- ³⁶ Robert A. Berenson et al., *Market Consolidation and High Prices*.
- ³⁷ Michael Chernew et al., Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans, Working Paper 24869 (Cambridge, MA: National Bureau of Economic Research, July 2018, revised January 2019), https://www.nber.org/system/files/working_papers/w24869/w24869.pdf.
- ³⁸ Sarah Kliff, “The Problem Is the Prices: Opaque and Sky High Bills Are Breaking Americans — and Our Health Care System,” *Vox*, October 16, 2017, <https://www.vox.com/policy-and-politics/2017/10/16/16357790/health-care-prices-problem>.
- ³⁹ Rabah Kamal and Cynthia Cox, “How Do Healthcare Prices and Use in the U.S. Compare to Other Countries?” Peterson-KFF Health System Tracker, May 8, 2018, <https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries/>.
- ⁴⁰ Glenn A. Melnick and Katya Fonkych, “Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems,” *Inquiry* 53 (June 2016), https://www.researchgate.net/publication/303891826_Hospital_Prices_Increase_in_California_Especially_Among_Hospitals_in_the_Largest_Multi-hospital_Systems.
- ⁴¹ Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Research Brief no. 16 (Washington, DC: Center for Studying Health System Change, November 2010), <http://www.hschange.org/CONTENT/1162/1162.pdf>.
- ⁴² *Sidibe v. Sutter Health*, 2019 U.S. District Court Northern District of California, <https://law.justia.com/cases/federal/district-courts/california/candce/3:2012cv04854/259136/678/>.
- ⁴³ Daniel G. Bird and Emilio E. Varanini, “Deciphering Sutter Health’s State-Court Settlement and Federal-Court Win in Parallel Antitrust Cases,” *Health Affairs Forefront*, May 10, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220509.99893/>.
- ⁴⁴ Bird and Varanini, “Deciphering Sutter.”
- ⁴⁵ *UFCW & Employers Benefit Trust v. Sutter Health*, 2015 California Court of Appeal, First Appellate District, <https://law.justia.com/cases/california/court-of-appeal/2015/a143399.html>.
- ⁴⁶ “UFCW & Employers Benefit Trust Files Antitrust Class Action Against Sutter Health: Suit Claims Violations of Cartwright Act and California’s Unfair Competition Law,” *GlobeNewswire*, April 7, 2014, <https://www.globenewswire.com/news-release/2014/04/07/1208760/0/en/UFCW-Employers-Benefit-Trust-Files-Antitrust-Class-Action-Against-Sutter-Health.html>.
- ⁴⁷ “Attorney General Becerra: State, Unions, Employers, and Workers Reach Settlement to Address Alleged Anticompetitive Practices by Sutter Health That Increased Healthcare Costs for Californians,” California Office of Attorney General, December 20, 2019, <https://oag.ca.gov/news/press-releases/attorney-general-becerra-state-unions-employers-and-workers-reach-settlement>.
- ⁴⁸ Bird and Varanini, “Deciphering Sutter.”
- ⁴⁹ Bird and Varanini, “Deciphering Sutter.”
- ⁵⁰ Tara Bano, “Federal Antitrust Case Against Sutter Headed for Appeal,” *Statnews*, April 2022, Available at: <https://www.statnews.com/2022/04/26/federal-antitrust-case-against-sutter-health-headed-for-appeal/>
- ⁵¹ “Health Insurance Coverage of the Total Population (Timeframe: 2019)”, Kaiser Family Foundation, n.d., <https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&selectedDistributions=employer--non-group&sortModel=%7B%22colId%22:%22Non-Group%22,%22sort%22:%22desc%22%7D>.
- ⁵² Reed Abelson, “Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic,” *New York Times*, August 5, 2020, <https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html>.

- ⁵³ Shrank, Rogstad, and Parekh, “Waste in the US Health Care System.”
- ⁵⁴ Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, eds. Mark Smith et al. (Washington, DC: National Academies Press, 2013), <https://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning>.
- ⁵⁵ Angela M. Antonelli, “The Aging of America: A Changing Picture of Work and Retirement,” Georgetown University Center for Retirement Initiatives, March 2018, <https://cri.georgetown.edu/the-aging-of-america-a-changing-picture-of-work-and-retirement/>.
- ⁵⁶ Daniel R. Arnold and Christopher M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages* (Santa Monica, CA: Rand Corporation, July 2020), https://www.rand.org/pubs/working_papers/WRA621-2.html.
- ⁵⁷ Christopher M. Whaley et al., *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative* (Santa Monica, CA: Rand Corporation, 2020), https://www.rand.org/pubs/research_reports/RR4394.html.
- ⁵⁸ Thomas M. Selden et al., “The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care,” *Health Affairs* 34, no. 12 (2015): 2147–2150, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0706>.
- ⁵⁹ Jared Lane Maeda and Nelson Lyle, *An Analysis of Private-Sector Prices for Hospital Admissions, Working Paper 2017-02* (Washington, DC: Congressional Budget Office, April 4, 2017), <https://www.cbo.gov/publication/52567>.
- ⁶⁰ Whaley et al., *Health Care Prices Paid*.
- ⁶¹ Whaley et al., *Health Care Prices Paid*.
- ⁶² Alison Kodjak, “That Surgery Might Cost You a Lot Less in Another Town,” *All Things Considered, National Public Radio* (NPR), April 27, 2016, <https://www.npr.org/sections/health-shots/2016/04/27/475880565/that-surgery-might-cost-you-a-lot-less-in-another-town>.
- ⁶³ Jessica Chang, Aditi P. Sen, Cristina Boccuti, “Price Markups for Clinical Labs: Employer-based Insurance Pays Hospital Outpatient Departments 3x More than Physician Offices and Independent Labs for Identical Labs,” Health Care Cost Institute and West Health, July 2022, <https://www.westhealth.org/resource/price-markups-for-clinical-labs-employer-based-insurance-pays-hospital-outpatient-departments-3x-more-than-physician-offices-and-independent-labs-for-identical-tests/>.
- ⁶⁴ Sarah Kliff and Josh Katz, “Hospitals and Insurers Didn’t Want You to See These Prices. Here’s Why,” *New York Times*, August 22, 2021, <https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html>.
- ⁶⁵ Kaiser Family Foundation, “Health Insurance Coverage.”
- ⁶⁶ Kliff and Katz, “Hospitals and Insurers.”
- ⁶⁷ Gary J. Young et al., “Community Benefit Spending by Tax-Exempt Hospitals Changed Little After ACA,” *Health Affairs* 37, no. 1 (January 2018): 121–124, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1028>.
- ⁶⁸ Bradley Herring et al., “Comparing the Value of Nonprofit Hospitals’ Tax Exemption to Their Community Benefits,” *Inquiry* 55 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813653/>.
- ⁶⁹ Sara Rosenbaum and Ross Margulies, “Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice,” *Public Health Reports* 126, no. 2 (2011): 283–286, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056045/>.
- ⁷⁰ “Limitation on Charges – Section 501(r)(5),” Internal Revenue Service, last reviewed or updated August 3, 2021, <https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5>.
- ⁷¹ Daniel B. Rubin, Simone R. Singh, and Gary J. Young, “Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice,” *Annual Review of Public Health* 36 (March 2015): 545–557, <https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031914-122357>.

- ⁷² “2022 Results – Fair Share Spending: How Much Are Hospitals Giving Back to Their Communities?” Lown Institute Hospitals Index, n.d., <https://lownhospitalsindex.org/2022-fair-share-spending/>.
- ⁷³ Lown Institute Hospitals Index, “Fair Share Spending.”
- ⁷⁴ Ge Bai and Gerard F. Anderson, “A More Detailed Understanding of Factors Associated With Hospital Profitability,” *Health Affairs* 35, no. 5 (May 2016): 889–897, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1193>.
- ⁷⁵ Lown Institute Hospitals Index, “Fair Share Spending.”
- ⁷⁶ Robert A. Berenson and Nancy M. Kane, “Policymakers Should Use Audited Financial Statements to Assess Health Systems’ Financial Health,” *To the Point* (blog), Commonwealth Fund, September 29, 2021, <https://www.commonwealthfund.org/blog/2021/policymakers-should-use-audited-financial-statements-assess-health-systems-financial>.
- ⁷⁷ Greg Rosalsky, “How Non-Profit Hospitals Are Driving Up the Cost of Health Care,” *Planet Money*, National Public Radio, October 15, 2019, <https://www.npr.org/sections/money/2019/10/15/769792903/how-non-profit-hospitals-are-driving-up-the-cost-of-health-care>.
- ⁷⁸ *Hospital Executive Compensation Report 2019* (Armonk, NY: Total Compensation Solutions LLC, April 2019), <http://www.total-comp.com/Total%20Compensation%20Solutions%202019%20Hospital%20Executive%20Compensation%20Report%20-%20Sample%20Report.pdf>.
- ⁷⁹ Adam Andrzejewski, Thomas W. Smith, “Top 82 U.S. Non-Profit Hospitals Quantifying Government Payments and Financial Assets”, Open The Books Oversight Report, June 2019.
- ⁸⁰ Jason Urbaniec, “C-Suite and Executives: Top 10 Highest Paid CEOs at Nonprofits 2021,” *ERI Blog*, Economic Research Institute, June 15, 2020, <https://www.eri.com/blog/post/top-10-highest-paid-ceos-at-nonprofits-2021>.
- ⁸¹ Urbaniec, “Highest Paid CEOs.”
- ⁸² Hannah Mitchell, “The 7 Highest-Paid Health System CEOs,” *Becker’s Hospital Review*, July 14, 2021, <https://www.beckershospitalreview.com/rankings-and-ratings/the-7-highest-paid-health-system-ceos.html>.
- ⁸³ Ayla Ellison, “Major Health Systems Report \$1B+ Annual Profits,” *Becker’s Hospital Review*, May 5, 2021, <https://www.beckershospitalreview.com/finance/major-health-systems-report-1b-annual-profits.html>.
- ⁸⁴ *Americans’ Views on Healthcare Costs, Coverage and Policy* (Chicago: NORC at the University of Chicago and West Health Institute, n.d.), <https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf>.
- ⁸⁵ Samantha Liss, “Hospital mergers can slow wage growth for nurses, others: study”, *Healthcare Dive*, March 19, 2021, <https://www.healthcaredive.com/news/hospital-mergers-can-slow-wage-growth-for-nurses-others-study/596980/>.
- ⁸⁶ Robert King, “Providers Push Congress to Include Value-Based Care Bill in \$3.5T Infrastructure Package,” *Fierce Healthcare*, August 25, 2021, <https://www.fiercehealthcare.com/payer/providers-push-congress-to-include-value-based-care-bill-3-5t-infrastructure-package>.
- ⁸⁷ *APM Measurement: Progress of Alternative Payment Models: 2020-2021 Methodology and Results Report* (McLean, VA: MITRE Corporation, 2021), <http://hcp-lan.org/workproducts/APM-Methodology-2020-2021.pdf>.
- ⁸⁸ U.S. Centers for Medicare & Medicaid Services, “BPCI Advanced,” CMS.gov, last updated June 29, 2022, <https://innovation.cms.gov/innovation-models/bpci-advanced>.
- ⁸⁹ Elliott S. Fisher, “Medicare’s Bundled Payment Program for Joint Replacement: Promise and Peril?” *JAMA* 316, no. 12 (2016): 1262–1264.
- ⁹⁰ Jacqueline LaPointe, “Joint Replacement Bundled Payment Cut Costs, Maintained Volume,” *Health Payer Intelligence*, February 14, 2017, <https://healthpayerintelligence.com/news/joint-replacement-bundled-payment-cut-costs-maintained-volume>.

- ⁹¹ Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation – Update* (Princeton, NJ: Robert Wood Johnson Foundation, 2012), <https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>.
- ⁹² Cheryl L. Damberg et al., “Measuring Success in Health Care Value-Based Purchasing Programs: Findings From an Environmental Scan, Literature Review, and Expert Panel Discussions,” *Rand Health Quarterly* 4, no. 3 (2014), <https://www.rand.org/pubs/periodicals/health-quarterly/issues/v4/n3/09.html>.
- ⁹³ Brittney A. Frankel and Tara F. Bishop, “A Cross-Sectional Assessment of the Quality of Physician Quality Reporting System Measures,” *Journal of General Internal Medicine* 31, no. 8 (2016): 840–845, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4945566/>.
- ⁹⁴ “What Is Pay for Performance in Healthcare?” NEJM Catalyst, March 1, 2018, <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245>.
- ⁹⁵ *Alternate Payment Model: APM Framework: Refreshed for 2017* (MITRE Corporation, 2017), <https://hcp-lan.org/apm-framework/>.
- ⁹⁶ “APM Measurement Effort,” Health Care Payment Learning & Action Network (HCPLAN), n.d., <https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/>.
- ⁹⁷ “Assessing Current and Expected Growth of Alternative Payment Models: A Look at the Bold New Goals for Downside Risk,” Leavitt Partners, November 18, 2019, <https://leavittpartners.com/assessing-current-and-expected-growth-of-alternative-payment-models-a-look-at-the-bold-new-goals-for-downside-risk/>.
- ⁹⁸ HCPLAN, “APM Measurement Effort.”
- ⁹⁹ Hoangmai H. Pham and Amol S. Navathe, “Why Aren’t Value-Based Payment Models More Successful? A Failure to Confront Market Dynamics,” *Health Affairs Forefront*, January 27, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220125.362333/>.
- ¹⁰⁰ Soraya Marashi, Newsom signs bill establishing Office of Health Care Affordability after negotiations, *State of Reform*, July 6, 2022, <https://stateofreform.com/featured/2022/07/newsom-signs-office-health-care-affordability-negotiations/>.
- ¹⁰¹ “State Legislative Action to Lower Health System Costs,” National Academy for State Health Policy, updated June 24, 2022, <https://www.nashp.org/health-system-costs-legislative-tracker/>.
- ¹⁰² U.S. Centers for Medicare & Medicaid Services, “Maryland Total Cost of Care Model,” CMS.gov, last updated June 13, 2022, <https://innovation.cms.gov/innovation-models/md-tccm>.
- ¹⁰³ U.S. Centers for Medicare & Medicaid Services, “Pennsylvania Rural Health Model,” CMS.gov, last updated June 23, 2022, <https://innovation.cms.gov/innovation-models/pa-rural-health-model>.
- ¹⁰⁴ Katherine Grace Carman et al., *The History, Promise and Challenges of State All Payer Claims Databases Background Memo for the State All Payer Claims Database Advisory Committee to the Department of Labor* (Santa Monica, CA: Rand Corporation, June 2021), <https://aspe.hhs.gov/sites/default/files/private/pdf/265666/apcd-background-report.pdf>.
- ¹⁰⁵ U.S. Centers for Medicare & Medicaid Services, “Hospital Price Transparency,” CMS.gov, last modified December 1, 2021, <https://www.cms.gov/hospital-price-transparency/hospitals>.
- ¹⁰⁶ Jessica Folker, “Lawmakers Pass Hospital Pricing Transparency Bill,” *Law Week Colorado*, May 11, 2022, <https://www.lawweekcolorado.com/article/lawmakers-pass-hospital-pricing-transparency-bill/>.
- ¹⁰⁷ “2022 Session: HB 481 Hospitals; Price Transparency,” Virginia’s Legislative Information System, n.d., <https://lis.virginia.gov/cgi-bin/legp604.exe?ses=221&typ=bil&val=HB481>.
- ¹⁰⁸ U.S. Centers for Medicare & Medicaid Services, “Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F),” CMS.gov, October 29, 2020, <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f>.



Our health care system has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills.

People First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low-quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high-quality care for all.

People First Care Series: Publication 2

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