FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Big Systems, Bigger Profits: Consumers Are Paying the Price of Corporate Hospital Power

America's health care affordability crisis is driven by a clear culprit: unchecked health care consolidation, particularly among hospitals, that gives big health care corporations the ability to set high and irrational prices with little to no accountability or improvement in health outcomes or quality.[1] As reaffirmed in this paper, with few truly competitive hospital markets left in the country, **most of our nation's families get their care through large corporate hospital systems that charge nearly three times more for hospital care than what Medicare pays for the same services.** These corporate health systems are charging excessive prices and raking in tens of millions of dollars each year, while patients and families struggle to pay their medical bills.

Executive summary

Families USA's new analysis of financial data and commercial insurance prices from over 2,800 hospitals across 49 states and the District of Columbia from 2018-2023 adds to the extensive academic evidence demonstrating that unchecked hospital consolidation and high hospital prices are a major driver of unaffordable health care across the United States, leading to substantial profits and operating margins for some of the largest corporate health systems in the country. These findings suggest that while corporate hospital chains often plead poverty to avoid accountability for their high and irrational prices, their own self-reported data indicates they are generating millions of dollars in profits. This analysis adds important data for policymakers to use in understanding hospital financial health and strengthens the rationale and urgency for holding corporate health systems accountable for charging excessive prices.

The report finds that a handful of corporate hospital systems in each state now control most of American hospital care. In 42 states and the District of Columbia, just **five or fewer health systems in each state controlled at least half of all hospital care in 2023.** In nearly half of all states, just three systems controlled the majority of care that year. This level of consolidation gives major hospitals the ability to set prices with no meaningful competition or accountability.[2]

Large hospital systems used their market power and **charged far more than the Medicare rate,** the only national, evidence-backed standard for fair pricing.

- The 15 largest systems in the country charged on average **2.82 times what Medicare paid** for the exact same services.
- Those big systems also raked in an average of more than **$22 million in net income per hospital per year.**
- No state was spared. **Average commercial hospital prices in every state were higher than what Medicare paid for the same services,** with average commercial prices in each state ranging from 157% to 365% of the Medicare rate. The most expensive states — Colorado, Florida, Georgia, New Mexico, South Carolina, West Virginia and Wisconsin — had average hospital prices ranging from 320% to 365% of the Medicare rate for the same services.

The biggest systems earned the most. Individual hospitals owned by a health system generated nearly 10 times more in annual net income ($27.7 million) than independent hospitals not owned by a health system ($3.0 million). Rural independent hospitals generated the lowest average net income ($2.3 million). Particularly large and expensive systems from the study period of note include the following:

- HCA Healthcare, the largest for-profit health system in the United States, operated 158 hospitals in our sample[i] across 20 states, charged an average of 339% of the Medicare rate for hospital services, and generated $70.3 million in annual net income per hospital.
- CommonSpirit Health, a Catholic health system that is currently the largest nonprofit hospital system in the country, operated 140 hospitals in our sample across 17 states, charged an average of 306% of the Medicare rate for hospital services, and generated $17.4 million in annual net income per hospital.
- Tenet Healthcare, a publicly traded for-profit system, operated 70 hospitals in our sample across 10 states, charged an average of 312% of the Medicare rate for hospital services, and generated $24.2 million in annual net income per hospital.
- AdventHealth, a nonprofit faith-based system, operated 38 hospitals in our sample across eight states, charged an average of 410% of the Medicare rate for hospital services, and generated $38.4 million in annual net income per hospital.

[i] The number of hospitals attributed to each system represent those included in our sample from 2018-2023, and does not account for the most recent data reflecting the number of hospitals owned by a health system. For example, as of April 2026, HCA Healthcare owned 190 hospitals compared to the 158 accounted for in our study period. See "HCA Healthcare Releases 2026 Impact Report," HCA Healthcare, April 10, 2026, https://hcahealthcaretoday.com/2026/04/10/hca-healthcare-releases-2026-impact-report/.

To be clear: nonprofit hospitals can charge exorbitant prices too. Despite their tax-exempt status granted on the premise that they provide community benefit, nonprofit hospitals charged nearly as much as for-profit hospitals (276% of the Medicare rate versus 297% of the Medicare rate, respectively) and brought in nearly as much in annual net income ($24 million versus $26.8 million, respectively), offering consumers no better protection from price gouging.

The biggest differentiator is whether a hospital is independent. Independent hospitals — hospitals not owned or affiliated with a health system — charged a much lower average commercial price of 221% of the Medicare rate and generated an average of $3 million in annual net income per hospital, a fraction of what system-owned hospitals collected. Rural independent hospitals charged the least of all, with an average commercial price of 216% of the Medicare rate, and generated an average of $2.3 million in annual net income. At the same time, rural hospitals owned by a system charged an average of 270% of the Medicare rate and brought in an average of $7.5 million in annual net income.

The data is clear, but one question remains: What will lawmakers do to hold big corporate hospital systems accountable for high health care costs?

Congress Must Act on Affordability

Voters across the political spectrum want Congress to lower health care costs and hold corporate health systems accountable for charging excessive health care prices.[3] Congress should immediately advance bipartisan reforms such as:

- **Enact site-neutral payments** so the same care costs the same everywhere.
- **Mandate full price transparency** across hospitals and health plans.
- **Ban anticompetitive practices** between hospital systems and insurers.
- **Strengthen oversight of nonprofit hospitals** to ensure real community benefit.
- **Limit hospital prices or hospital price growth** relative to Medicare benchmarks.

Ultimately, these policy reforms would directly curb excessive prices, boost competition and deliver meaningful cost relief for American families. Failing to advance hospital pricing reforms would only continue to force health care consumers to bear the brunt of our country's health care affordability crisis while allowing large corporate health systems to overcharge for care and generate financial windfalls at consumers' expense.

Patients pay the price for hospital consolidation

Hospitals serve an essential role in the U.S. health care system and in their communities. They provide lifesaving services for acute and complex conditions. They train doctors, nurses and other health care providers, and are an important source of jobs and economic activity in communities. But the role of hospitals in our economy has shifted drastically over the last 60 years.[4] 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.[5] Fundamentally, **the business interests of the hospital sector are no longer aligned with the interests of the patients they serve.**

Long-standing evidence shows that excessive health care costs in the United States are largely driven by unchecked consolidation. Corporate hospital systems have been buying up hospitals and physician practices to dominate local markets — then leveraging that power to raise prices and maximize service volume.[6] **Over the last 25 years, unchecked hospital consolidation has driven up hospital prices by over 220%.**[7] These high hospital prices have resulted in a 320% increase in family health insurance premiums since 2000.[8] As a direct result, Americans are increasingly struggling to manage rising health care expenses and are fearful of what a medical emergency could mean for their finances.[9]

One-third of U.S. adults skip or delay needed health care due to cost.[10] Over 100 million people in the U.S. have medical debt totaling over $200 billion, leading many to make significant sacrifices, such as cutting back on necessities like food or taking on credit card debt, which they may never be able to pay back.[11] Moreover, these high hospital prices come directly out of workers' paychecks in the form of higher premiums and out-of-pocket health care costs, which have resulted in nearly $1 trillion in lost workers' wages since 2012.[12]

What makes the extraordinarily high cost of our hospitals particularly egregious is how that spending has no relationship to the quality of care or health outcomes. The U.S. has some of the worst health outcomes and lowest levels of access to care compared with other Organization for Economic Co-operation and Development (OECD) countries.[13] One of the best indicators for the quality of a health care system is avoidable mortality — the measure of preventable and treatable deaths that could be avoided with timely and effective interventions. The U.S. has substantially higher avoidable mortality than the average of other OECD countries in 2025. In the U.S., the number of preventable deaths was 217 per 100,000 people, compared with 145 per 100,000 people in OECD countries on average.[14] The number of treatable deaths in the U.S. was 95 per 100,000 people, compared with OECD's average of 77 per 100,000 people.[15] In other words, despite the fact that hospital and physician care account for half of U.S. health care spending,[16] the system fails to provide timely and effective interventions to save Americans' lives. In fact, sometimes hospital care makes people sicker. On any given day, 1 in 31 hospital patients have at

least one health care associated infection.[17] Our health care system also has worse health outcomes than other advanced countries as evidenced by having among the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[18]

Families USA's analysis

Families USA conducted an original analysis examining hospital markets and commercial insurance prices using hospital financial data sourced from the National Academy for State Health Policy (NASHP) Hospital Cost Tool[19] from 2018-2023. Data used in this analysis came from across 49 states[ii] and Washington, D.C., accounting for 57% of U.S. hospitals and commercial insurance price data compiled in the NASHP Hospital Cost Tool from RAND research.[20] The data reveals that hospitals across America are charging excessive health care prices and generating significant operating margins. The results of this analysis are consistent with existing empirical evidence that health care consolidation, particularly among hospitals, leads to high and variable health care prices and costs for the 182 million Americans who rely on commercial insurance for health care and adds key information about the scale and scope of the operating margins and profits of some of the largest health systems in the country.[21]

Hospital Finances and H.R. 1: The Burden Falls Unevenly

Corporate hospital systems and their lobbyists have long deflected criticism about their pricing policies by pointing to the challenges faced by financially vulnerable hospitals. They are doubling down on this strategy to escape scrutiny now that some hospitals, particularly rural independent and safety net providers, are facing additional financial strain from forthcoming cuts in federal Medicaid funding.

The 2025 budget reconciliation law (H.R. 1) will result in significant coverage losses for many low-income consumers, as well as budgetary difficulties for providers and states. This legislation further compounds our nation's health care affordability crisis — a crisis long driven by large corporate hospital systems leveraging their market power to charge consumers with commercial coverage inflated prices in order to generate substantial profits.

Challenges experienced by vulnerable hospitals should not be used to justify maintaining excessive prices across the broader hospital sector. Doing so only further harms patients and families while allowing large corporate health systems to brazenly overcharge for care.

[ii] Maryland and Maryland hospitals were excluded from the sample due to data availability. For more information, see the appendix.

This analysis uses Medicare payment rates as a benchmark because Medicare serves as the only national effort to establish a fair price for health care, even with inherent flaws.[22] In most cases, the prices established for Medicare services become the basis for the prices paid by Medicaid and commercial insurance. Additionally, Medicare rates are adjusted geographically to account for variation in the costs incurred by providers.[23]

Most working-age Americans receive health care through their employers and private insurance.[24] In these markets, prices are largely determined through closed-door negotiations between insurers and providers.[25] However, **the growing market power of consolidated hospital systems has weakened insurers' ability to secure lower prices.**[26] As a result, commercial hospital prices — one of the primary drivers of rising premiums — have grown much faster than Medicare payments.[27]

Against this backdrop, this analysis highlights variation in hospital financial health across the country. This finding is foundational to the policy reforms recommended in this paper.

Detailed findings

Through this analysis, Families USA identified the 15 largest hospital systems included in the dataset to further analyze the relationship between hospital consolidation and prices (Table 1, page 7). Across the 15 largest hospital systems, the weighted average commercial price for hospital services was 282% of what Medicare charged for the same hospital services and ranged up to 410% of the Medicare rate for select systems. All but one of the top 15 health systems had average annual net income in the millions, with annual net income for those 14 health systems ranging from $3.3 million to more than $70.3 million per hospital (Table 1).

The largest hospital system in the country is HCA Healthcare, which operated 158 hospital locations across 20 states from 2018-2023 (Table 1). Hospitals owned by HCA Healthcare charged on average 339% of the Medicare rate (Table 1), resulting in an average of $70.3 million in annual net income per hospital from 2018-2023. HCA Healthcare reported total net income of $5.242 billion in 2023 across all its facilities.[28]

Similarly, CommonSpirit Health, a nonprofit hospital system that grew to be the second-largest hospital system in the country following a 2019 merger between Dignity Health and Catholic Health Initiatives, charged over three times what Medicare paid for health care services, contributing to over $17 million in average annual net income per hospital. (Table 1).[29] In total, CommonSpirit Health reported total net income of $283 million in 2023.[30]

Table 1: Average Commercial Price and Average Annual Net Income Per Hospital Across the 15 Largest Health Systems, 2018-2023

System name	Total number of hospitals in sample	Average number of hospitals with available data per year	Number of states where hospital system is present	Weighted average commercial price (percentage of Medicare rate)	Average annual net income per hospital
HCA Healthcare	158	114.3	20	339%	$70,280,582.55
CommonSpirit Health[iii]	140	56.3	17	306%	$17,350,501.73
Ascension Health	101	58.5	12	253%	$12,553,234.57
Trinity Health Michigan	99	44.7	15	296%	$18,532,536.41
Quorum Health Corporation	94	29.5	30	242%	$3,331,026.46
Catholic Health Initiatives[iv]	86	18.8	13	241%	$12,349,324.88
Community Health Systems	82	65.2	19	284%	$21,554,633.90
Lifepoint Health	77	59.5	27	284%	$6,421,650.07
Tenet Healthcare	70	47.3	10	312%	$24,193,649.87
Providence	55	44.2	7	261%	–$3,538,407.60
Advocate Health	47	12.3	4	318%	$59,443,072.82
Prime Healthcare Services	42	35.3	14	253%	$5,416,631.21
AdventHealth	38	24.2	8	410%	$38,371,570.58
Avera Health	37	9.7	4	235%	$6,222,912.95
Mercy	37	21.2	4	202%	$38,678,290.89
15 largest hospital systems	**1,163**	**N/A**	**47**	**282%**	**$22,077,414.08**

This analysis also found that, as of 2023, 42 states and the District of Columbia had hospital markets that have consolidated to the point that just five or fewer health systems delivered at least half of all care in the state (Table 2, page 8). In 22 states and the District of Columbia, just three health systems delivered over 50% of all hospital care (Table 2). This finding aligns with existing research that shows that 97% of metropolitan statistical areas exceed antitrust thresholds for high concentration, with 19% of inpatient hospital markets being totally controlled by a single system.[31] Taken together, this data shows that most of health

[iii] CommonSpirit Health data spans 2020-2023 following the merger between Catholic Health Initiatives and Dignity Health
[iv] Data from Catholic Health spans 2018 and 2019, prior to their merger with Dignity health to form CommonSpirit Health.

care across the United States is now being delivered by just a few highly consolidated hospital systems that charge significantly higher rates than what Medicare pays for the same services. These trends in consolidation are driven by hospitals, health systems and other providers engaging in both horizontal consolidation (that is, mergers between hospitals) and vertical integration (that is, mergers between hospitals and other health care providers) to amass significant market power, which they then leverage to increase health care prices year after year with no accountability.[32]

Table 2: Average Commercial Hospital Price, Average Annual Net Income Per Hospital, and Market Share of the Five Largest and Three Largest Hospital Systems by State, 2018-2023

State	Weighted average commercial price, 2018-2023 (percentage of Medicare rate)	Average annual net income per hospital, 2018-2023	Estimated market share of five largest hospital systems, 2023	Estimated market share of three largest hospital systems, 2023
Alabama	211%	$12,291,298.18	51%	36%
Alaska	287%	$39,258,443.97	46%	36%
Arizona	289%	$42,322,503.74	70%	57%
Arkansas	157%	$8,312,333.04	49%	35%
California	318%	$20,704,755.16	42%	31%
Colorado	328%	$29,509,591.76	74%	54%
Connecticut	249%	$13,300,734.79	81%	67%
District of Columbia	249%	$53,993,222.81	95%	86%
Delaware	318%	$54,645,298.41	100%	85%
Florida	353%	$45,517,934.72	51%	40%
Georgia	320%	$30,115,964.38	57%	41%
Hawaii	276%	$22,305,444.32	96%	76%
Idaho	308%	$20,996,384.51	73%	59%
Illinois	260%	$24,363,818.78	47%	33%
Indiana	319%	$34,853,392.64	52%	35%
Iowa	221%	$14,089,204.43	74%	68%
Kansas	291%	$15,004,094.25	59%	46%
Kentucky	254%	$19,473,881.06	61%	43%

State	Weighted average commercial price, 2018-2023 (percentage of Medicare rate)	Average annual net income per hospital, 2018-2023	Estimated market share of five largest hospital systems, 2023	Estimated market share of three largest hospital systems, 2023
Louisiana	240%	$16,216,709.70	63%	50%
Maine	249%	$2,100,649.69	87%	72%
Maryland[v]	N/A	N/A	64%	51%
Massachusetts	176%	$18,100,780.56	60%	45%
Michigan	207%	$10,595,929.20	63%	44%
Minnesota	234%	$19,833,165.21	65%	46%
Mississippi	207%	$7,024,385.04	56%	41%
Missouri	253%	$17,588,933.51	58%	46%
Montana	266%	$14,503,123.44	59%	39%
Nebraska	301%	$20,329,497.86	69%	53%
Nevada	293%	$25,207,056.42	84%	68%
New Hampshire	230%	$21,785,942.57	72%	52%
New Jersey	261%	$21,369,447.54	58%	47%
New Mexico	325%	$15,992,255.67	66%	51%
New York	286%	$14,649,974.80	39%	27%
North Carolina	294%	$38,210,132.28	66%	53%
North Dakota	215%	$17,315,381.66	90%	71%
Ohio	277%	$30,578,458.84	51%	37%
Oklahoma	243%	$17,584,815.37	58%	38%
Oregon	268%	$10,153,600.84	58%	43%
Pennsylvania	248%	$23,816,652.20	48%	35%
Rhode Island	199%	–$799,020.04	95%	82%
South Carolina	365%	$25,429,953.94	65%	48%
South Dakota	245%	$20,621,400.34	82%	80%
Tennessee	236%	$19,209,635.39	49%	33%
Texas	259%	$37,997,528.96	44%	32%
Utah	239%	$37,556,156.62	95%	87%
Vermont	282%	$4,444,723.99	76%	76%
Virginia	284%	$42,339,900.62	60%	43%
Washington	232%	$3,818,248.27	74%	56%
West Virginia	337%	$14,123,911.82	89%	84%
Wisconsin	322%	$21,020,382.62	52%	38%
Wyoming	306%	$6,120,319.98	61%	48%

[v] Maryland and Maryland hospitals were excluded from the sample due to data availability. For more information, see the appendix.

Independent and rural independent hospitals, which are not owned by larger health systems, generated significantly lower than average earnings.

While all states have high hospital prices, Families USA found particularly high average hospital prices in Colorado, Florida, Georgia, New Mexico, South Carolina, West Virgina and Wisconsin, with prices as a percentage of the Medicare rate ranging from 320% in Georgia to 365% in South Carolina (Table 2). These states have highly concentrated markets that have enabled hospitals to use their market power to charge alarmingly high prices. Across these states, 51% to 89% of all hospital care is delivered by the five largest health systems, and 38% to 84% of care is delivered by the three largest health systems (Table 2). Moreover, across nearly every state, hospitals generated millions of dollars in income annually. Rhode Island was the only state with negative average annual net income per hospital, meaning the hospital data for the state demonstrated average losses of nearly $800,000 per year over the six-year period.[vi]

These high prices, discussed in further detail below, have resulted in significant margins or profits, with hospitals earning more than $23 million in annual net income on average from 2018-2023.[vii] **Meanwhile, independent and rural independent hospitals, which are not owned by larger health systems, generated earnings that were significantly lower than the average over the same period.** In fact, system-owned hospitals generated nearly 10 times more in annual net income ($27,681,819) from 2018-2023 than independent hospitals over the same period ($3,016,441) (Table 3, page 11). These findings suggest that independent hospitals generating less income may be more financially vulnerable to certain policies targeting price reductions whereas the largest health systems that can increase prices due to their market power and generate substantial margins or profits could be better positioned to absorb the financial impact of such reductions.

[vi] Families USA found significant variation in net income, year over year for several Rhode Island hospitals, with some hospitals reporting millions of dollars in profits one year but substantial financial losses the next year. These annual fluctuations in profits and losses often occurred with little reported variability in net patient revenue or operating costs, suggesting that for these Rhode Island hospitals, patient revenue alone was not sufficient to cover hospital operating costs, resulting in negative average annual net income per hospital.

[vii] Net income as defined under key terms on page 16.

Table 3: Average Annual Net Income and Average Commercial Price by Hospital Designation, 2018-2023

Hospitals charged commercially insured patients over 2.7 times what Medicare paid for the same service from 2018-2023. System-owned, for-profit and urban hospitals charged the highest prices.

Designation	Total number of hospitals in sample with available data	Average number of hospitals with available data per year	Weighted[viii] average commercial price (percentage of Medicare rate)	Average annual net income per hospital
Rural	1,269	905.00	258%	$5,629,537.37
Urban	2,187	1,903.50	276%	$32,097,734.69
Independent	848	468.33	221%	$3,016,441.11
System	2,824	2,340.17	277%	$27,681,818.70
Rural independent	594	328.67	216%	$2,268,470.29
Rural system	798	576.33	270%	$7,546,259.26
Urban independent	254	139.67	227%	$4,776,582.47
Urban system	2,026	1,763.83	278%	$34,261,121.78
For-profit	609	482.17	297%	$26,776,786.00
Governmental	698	479.50	243%	$18,634,848.00
Nonprofit	2,246	1,846.83	276%	$24,012,175.00
All hospitals	**3,456**	**2,808.50**	**274%**	**$23,568,727.00**

As a result of unchecked consolidation, U.S. hospitals charged consumers with commercial insurance on average over 2.7 times what Medicare would have paid for the same hospital services from 2018-2023, with system-owned hospitals charging the highest amounts (Table 3). These higher health care prices translate into higher premiums and out-of-pocket costs for the over 182 million people who rely on commercial health insurance for their health care.[33] In fact, in the 2026 insurer rate filings that determine the premium rate increases for the health insurance marketplace, insurers identified high hospital prices as one of the top drivers of rising insurance premiums.[34]

[viii] Commercial price is representative of the allowable commercial prices as a percentage of the fee-for-service price in Medicare for the same service. Families USA produced a weighted average based on the number of discharges each location reported during the applicable year.

While highly consolidated hospital markets result in higher prices overall, this analysis found that certain categories of hospitals were more likely to charge high prices compared with others.[35] For example, hospitals owned by large health systems, private for-profit and nonprofit hospitals, and urban hospitals were most likely to charge inflated prices for hospital care compared with independent, public and rural hospitals.

Notably, the largest and most horizontally consolidated health systems — that is, health systems that own more than 50 hospitals — charged on average 296% of the Medicare rate from 2018-2023, accounting for some of the highest prices in the sample (Table 4, page 13). From 2018-2023, hospitals that were owned by systems of all sizes made an average of nearly $28 million per year in net income (Table 3). Importantly, during this same period, health insurance premiums in the commercial market increased 21%.[36]

This means that **hospitals across the country generated millions of dollars in profits and operating margins from their ability to consolidate market power and increase health care prices without regard for America's families' increasing struggle to pay their medical bills and afford their care.**[37] Further, the excessive prices and operating margins generated by non-profit hospitals are particularly alarming given how little difference there is in the prices they charge and margins they generate from their for-profit counterparts. This means, for all the protections they are given under their tax-exempt status, non-profit health systems continue to be major drivers of our nation's health care affordability crisis.

While highly consolidated hospital markets tend to have higher average hospital prices, there is still significant variation across health systems and states. This variation reflects differences in negotiated rates, which are shaped by the relative market power of hospitals and insurers. Insurers negotiate these prices as a part of building provider networks, but in markets where dominant hospital systems are considered "must-have" for a viable network, insurers have less leverage to secure lower rates.[38] Conversely, in markets where insurers are more concentrated, they may have greater leverage to negotiate lower prices, moderating overall hospital costs.[39]

The prices and net incomes of corporate hospital systems are particularly egregious when compared with that of independent hospitals and independent rural hospitals. For example, independent hospitals on average charged 221% of the Medicare rate for hospital services, far lower than what system-owned hospitals charged, at 277% of the Medicare rate (Table 3). This disparity in price is even greater when comparing independent rural hospitals with rural hospitals that are owned by health systems. This analysis found that from 2018-2023, rural independent hospitals charged commercial insurers 20% less than rural system-owned hospitals (Table 3). Rural system-owned hospitals also had significantly higher average annual net income of $7,546,259 from 2018-2023, compared with $2,268,470 for rural independent hospitals in the same period (Table 3).

These findings are consistent with the broader evidence base showing that **smaller independent hospitals are less likely than large hospital systems to use anticompetitive practices to charge inflated prices** and have a different financial outlook than the largest health systems in the country.[40]

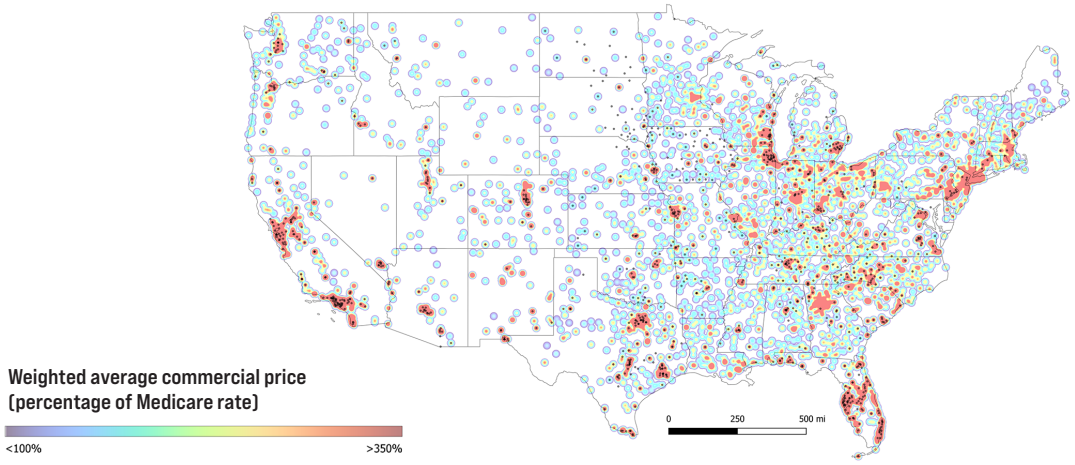
Table 4: Average Commercial Price and Average Annual Net Income by Hospital System Size, 2018-2023

Hospitals owned by large hospital systems were more likely to charge high prices than smaller hospital systems and independent hospitals.

Number of hospitals owned by a system	Number of systems in this category	Weighted average commercial price (percentage of Medicare rate)	Average annual net income per hospital
1	240	259%	$20,652,808.34
2-10	285	270%	$32,756,876.52
11-20	30	281%	$27,731,611.59
21-30	12	264%	$26,005,932.76
31-40	8	260%	$23,181,948.96
41-50	3	277%	$20,440,432.14
51+	7	296%	$24,412,398.44

The relationship between health care consolidation and high hospital prices is clearly represented in Figure 1, which overlays the locations of hospitals owned and operated by the 15 largest health care systems (represented by black dots) with a heat map of average hospital prices (represented by color, with purple identifying the lowest prices and red identifying the highest prices).

Figure 1: The 15 Largest Health Care Systems and Hospital Prices, 2018-2023[ix]



[ix] The circle around each hospital encompasses a radius of 15 miles and reflects the average price charged by that hospital. This is done for illustrative purposes and should not be thought of as a representation of the true size of the area served by any particular hospital.

As shown in Figure 1 (page 13), the largest hospital systems owned and operated hospitals in the majority of geographic areas with average prices above 300% of the Medicare rate. Clusters of hospitals owned and operated by the largest health systems appear most densely in the regions with the highest prices, including in California, Florida and Texas (Figure 1). Unsurprisingly, 46 states had at least one hospital owned and operated by one of these large systems, and many of those facilities align directly with the state's highest priced hospital markets (Figure 1).

Policy solutions to advance affordability

This analysis adds to existing research demonstrating that unchecked hospital consolidation, particularly among the largest corporate hospital systems, results in high hospital prices that act as a central contributor to our nation's health care affordability crisis. Voters across the political spectrum are pleading for Congress and the president to lower health care costs and root out the corporate greed in the health care system. At a time when policymakers are seeking solutions that resonate with voters, Congress has both the opportunity and the responsibility to hold corporate health systems accountable for charging excessive health care prices.

Congress Should Enact These Bipartisan Reforms

1. **Enact site-neutral payment** (same service, same price) legislation to stop big hospital corporations from charging more for the same routine care and shifting patients to higher-cost health care settings.
2. **Require price transparency across all hospitals and health plans,** including by enacting the Patients Deserve Price Tags Act.[41]
3. **Prohibit anticompetitive practices** between big hospital systems and health plans, including by enacting the Healthy Competition for Better Care Act[42] and addressing vertical consolidation by enacting the Break Up Big Medicine Act.[43]
4. **Increase oversight of nonprofit tax-exempt hospitals** to ensure their federal tax benefit is commensurate with direct measures of the health improvements and cost of care being delivered to the communities they serve.
5. **Establish a limit on the maximum price or the price growth rate of hospital services** as a percentage of the Medicare rate to prevent hospitals from charging exorbitantly high prices, as seen in Indiana and Vermont.[44]

Conclusion

High and rising hospital prices are a central driver of the nation's health care affordability crisis. Families are facing record levels of medical debt, are paying higher premiums and deductibles, and are increasingly forced to delay or to forgo needed care.[45] This analysis underscores the scale of the problem. Commercial hospital prices average nearly three times Medicare rates for the same services, with some large systems charging more than four times as much. These price differences are not explained by better care quality or improved outcomes but instead reflect growing market power driven by consolidation.

As a result, large corporate hospital systems generate substantially higher margins than independent hospitals. Their financial strength and reliance on higher commercial prices leave them well positioned to adapt to policies that reduce excessive pricing and make health care more affordable for American families.

Excessive hospital pricing is a systemic problem, but it is solvable. Congress has clear tools available, including increasing price transparency, strengthening oversight of consolidation, and curbing anticompetitive and abusive pricing practices to bring prices closer to reasonable benchmarks. Lowering hospital prices would reduce costs for families and employers and improve access to care. The question is not whether solutions exist but whether there is the political will to act.

Appendix

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Key terms

Net income is defined as net patient revenue minus operating expenses plus other sources of income and expenses, such as investment losses, representing the earnings retained by the hospital. Moreover, net patient revenue is defined as total gross patient charges minus contractual discounts, bad debt and charity care allowances, and other deductions agreed to by the hospital.

Average annual net income represents net income on average per hospital per year.

System affiliation status is defined as whether a hospital is affiliated with a health system according to the Agency for Healthcare Research and Quality (AHRQ) Compendium U.S. Health Systems database for the years 2018-2022. According to AHRQ, a health system includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management. Moreover, a health system includes at least one nonfederal acute care hospital, at least 50 total physicians, and at least 10 primary care physicians. A total of 216 hospitals in our sample changed system affiliation between 2018 and 2023.

Adjusted patient discharges are defined as the hospital's total number of inpatient and outpatient hospital discharges for both Medicare and commercially insured patients.

Market share is defined as the percentage of patient care a specific hospital or hospital system controls within a state. To calculate the estimated market share of the five largest and three largest hospitals in a state, Families USA calculated the percentage of a state's total patient discharges attributed to the largest health systems located in the state.

Average commercial price is defined as the relative price (as reported by RAND) of hospital services compared with what Medicare pays for those same services.46 It is reported as a percentage of the Medicare price, where 100% is equal to the Medicare price.

Weighted average commercial price is the average commercial price of a given sample of hospitals, weighted by the adjusted patient discharges of each individual hospital in a particular year. Families USA calculated weighted average commercial price to account for differences in patient volume from hospital to hospital.

Methodology

Families USA conducted an original analysis examining the state of hospital pricing and hospital markets across 49 states (excluding Maryland[x]) and the District of Columbia in order to highlight the role of industry consolidation and hospital market power in driving high and rising health care costs across the U.S.

The analysis principally relies on hospital pricing and financial data from Medicare cost reports, as maintained in the national Healthcare Cost Report Information System, covering calendar years 2018, 2019, 2020, 2021, 2022 and 2023, as well as commercial health care claims data from self-insured employers, state employee health plans, and all-payer claims databases from select states. These data sources were compiled and synthesized by the National Academy for State Health Policy (NASHP) and include individual hospital data as well as the following data: average hospital prices paid by commercial health plans expressed as a percentage of the Medicare rate, accounting for Medicare's hospital-specific adjustments such as local wage indexes and increased payments for sole community hospitals; hospital ownership type (that is, whether a hospital is classified as nonprofit, for-profit or governmental); adjusted patient discharges; address information, including ZIP code; system affiliation status; and net income.

Importantly, due to the sampling method of the underlying academic study that NASHP used to compile and calculate average hospital prices, this analysis only includes data on a subset of all U.S.-based hospitals, including Medicare-certified nonfederal short-stay general hospitals, such as academic medical centers. Hospitals explicitly excluded from this analysis include certain specialty hospitals, such as cancer hospitals, psychiatric hospitals, long-term care hospitals and children's hospitals, as well as hospitals owned and operated by the U.S. Department of Veterans Affairs.

The original dataset included 4,484 hospitals, but Families USA cleaned the data to remove any hospitals that did not report average hospital prices or net income data in a particular year. This left a total of 3,456 hospitals from 2018-2023 in the sample. However, not every hospital in our sample had this data available for all six years. An average of 2,808.5 hospitals in our sample reported these data points each year.

[x] Maryland operates a hospital payment and rate-setting system in which all payers pay the same rates. As a result, the state has been excluded from datasets, including the RAND national hospital price transparency report that was used to collect average commercial price data for this publication. Therefore, Maryland has been excluded from our dataset. For more information, see Robert Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," Health Affairs 28, no. 5 (2009), https://www.healthaffairs.org/doi/10.1377/hlthaff.28.5.1395; "Frequently Asked Questions (FAQs)," RAND Health Care Price Transparency Initiative, Round 5, RAND Corporation, n.d., https://www.rand.org/health/projects/hospital-pricing/round5/faq.html.

The analysis also relies on a crosswalk analysis — created by the Cecil G. Sheps Center for Health Services Research at the University of North Caroliina at Chapel Hill — between a hospital's unique provider number and its associated metropolitan statistical area (MSA), which is defined as a geographic area with a population of at least 50,000 people. This crosswalk was used to identify an individual hospital's status as either urban or rural. Hospitals located inside an MSA were classified as urban with all other hospitals classified as rural.

Based on this data, Families USA calculated both the average commercial prices for inpatient and outpatient hospital services charged by hospitals for commercially insured patients, and the amount of profit or margins hospitals generated, measured by annual net income. Importantly, these estimates were calculated for all individual hospital locations identified in the NASHP hospital data described above as well as by select groups of hospitals, including hospitals identified as being located in urban or rural areas; hospitals located in specific U.S. states; hospitals identified as either nonprofit, for-profit or governmental (that is, public); and hospitals that are owned or under joint management by a larger health system or are independent. To account for any outliers in hospital financial data associated with a particular calendar year, these estimates, including average commercial prices and average annual net incomes, were calculated using Medicare cost reporting and commercial health care billing data across multiple reporting periods, including calendar years 2018, 2019, 2020, 2021, 2022 and 2023.

To account for patient volume, Families USA calculated and reported a weighted average for commercial price based on the number of adjusted patient discharges each location reported that year. This was done to prevent the overrepresentation of hospitals that deliver a lower volume of care from skewing the averages, such that it more accurately reflects typical prices and the average patient's experience. Weighted average commercial prices and average net income per hospital per year were calculated and reported for many variables, including by system affiliation, location, state, system size and hospital designation.

Families USA used the NASHP hospital data to assess the relative sizes of the U.S. health systems that owned and operated individual U.S. hospitals in our sample. Once Families USA calculated the total number of individual hospital locations that each health system owned and operated as of calendar year 2023, Families USA then calculated, via a weighted average, the price such health systems charged commercially insured patients per individual hospital location. This allowed Families USA to observe the extent to which health system size is correlated with differences, and in this case, higher average commercial hospital prices.

Lastly, Families USA, created a measure to estimate the statewide market share of U.S. health systems, as measured by the percentage of adjusted patient discharges across all 4,484

hospitals in the full dataset (not the cleaned sample as discussed above). To do this, Families USA took the following steps: first, Families USA used the adjusted patient discharges field in the NASHP hospital data to calculate total patient discharges by state; second, Families USA calculated total patient discharges among individual hospitals owned by the same health system to create a measure of total patient discharges delivered across the entire health system by each U.S. state; and third, Families USA calculated the percentage of patient discharges delivered by each health system within each state. Ultimately, Families USA used this information to calculate the percentage of patient discharges out of the total statewide patient discharges delivered by the five and three health systems that delivered the greatest number of patient discharges in each state (that is, the largest five and largest three health systems in the state).

Limitations

While Families USA designed this analysis to maximize the reliability, accuracy and generalizability of its findings, important data limitations remain. First, the average hospital prices source by NASHP relied on commercial claims data for only a subset of commercial patients, including self-insured plans sponsored by the employers that chose to participate in this study, enrollees of health plans that contributed to all-payer claims database medical claims, and enrollees in the private insurance plans that submitted data. Therefore, the claims data included in this study represent a portion of the entire population of privately insured patients and may not be fully representative of the prices paid by the broader privately insured population.

Second, while Families USA used multiple reporting years to calculate certain measures, outliers may still exist in the underlying data and skew the ability of our findings to accurately assess hospitals' average commercial prices and long-term financial health as measured by net income. For instance, two of the five years of underlying hospital data used were collected during calendar years 2020 and 2021 when the COVID-19 pandemic was at its height and when many hospitals received COVID-era relief funds. Importantly, during this time, hospital discharges, revenues and net incomes were abnormally low due to stay-at-home orders that restricted individuals from accessing routine health care services or elective surgeries in person.

Third, RAND prices are computed as an aggregate of paid claims over several years. As a result, average price data for hospital locations that changed ownership (from one system to another or from independent to system-affiliated) year over year may reflect a mix of pre- and post-acquisition claims data in some cases. It is unclear how this may impact average price data overall.

Lastly, the removal of 1,028 hospitals from the sample due to missing data may affect the generalizability of our findings to the total population of U.S. hospitals. Removing this data could have introduced potential biases in the sample that may have skewed some of the results. As a result, the calculated values for average price and net income are reflective of our cleaned sample, rather than the full population of hospitals.

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