Promoting Hospital Accountability:
A Policy Agenda for Employers and Working Families

Healthcare is increasingly unaffordable for working families. Every day, Americans are paying more through higher premiums, out-of-pocket costs, and medical debt.

This includes over 150 million Americans who receive health benefits through employer-sponsored insurance, including workers covered by employers in the private, public, and nonprofit sectors, as well as labor unions.[1]

Employers want to provide competitive wages and strong health benefits to their employees. But when healthcare costs rise year after year, they are forced to make increasingly difficult choices, such as increasing out-of-pocket healthcare costs or forgoing wage increases. **Today, the average annual premium for family coverage is nearly $27,000**, with employers paying roughly $20,000 and workers contributing almost $7,000 from their paychecks each year.[2]

Hospital spending is a major driver of this trend. It is the single largest component of healthcare spending in the United States, reaching roughly $1.6 trillion in 2024 and accounting for 40% of growth in national health spending between 2022 and 2024.[3] Since 2000, hospital prices have risen by 220% — far outpacing both inflation and the growth of other medical prices.[4]

Higher hospital prices are not simply the result of rising demand for healthcare or the development of new and more complex treatments. They reflect deeper, structural flaws in how hospital markets operate today, including market consolidation, misaligned financial incentives, and limited transparency into how public subsidies and negotiated payments are used. Together, these forces are driving up prices and making it harder for working families to afford coverage and care.

In addition, these trends are reshaping incentives across the healthcare system in ways that will make costs harder to control over time. As consolidation increases and payment differentials widen, employers face fewer meaningful options to steer patients toward higher-value care. At the same time, public subsidies and opaque pricing structures can reinforce higher-cost delivery models.

The longer these dynamics persist as structural elements of the hospital market, the harder they will be to reverse — making timely, targeted policy action an urgent priority for employers and working families.

The Problem:

High and Rising Hospital Prices Drive Healthcare Affordability Challenges

Employers are using the tools available to negotiate competitive prices, but structural barriers — including incomplete data, limited transparency, and the market power that comes from consolidated systems — are making it increasingly difficult to secure fair prices. These barriers point to three interrelated policy problems that must be addressed to reduce the burden of healthcare costs on working families.

1 Lack of transparency hides true costs and hinders efforts to contain costs

Transparency by the Numbers:

- Despite being signed into law in 2021, only **21% of hospitals were fully compliant** with federal price transparency requirements as of 2024.[5]
- Prices for the same exact service can **vary by as much as 3,100%** between hospitals within a single state.[6]
- About one-third of employers cannot access complete claims data, and **4 in 10 report that vendors refuse** to provide it.[7]
- **91% of employers question** whether hospital prices are reasonable, and 63% report concerns about billing integrity.[8]

Same Service, Different Price

In the Detroit metro area, the total cost of a hip or knee replacement can vary by more than **$20,000** between high-quality hospitals. For every **150 employees** who need one of these procedures, choosing a lower-cost option — even within the same health system — could save employers more than **$3 million**.[9] However, a lack of transparency inhibits employers from designing benefits around value and costs.

A competitive healthcare market can function to keep prices low — but only if employers have the information they need to assess value and control costs.

Hospital prices today are obscured by incomplete disclosures, opaque contracting, and billing practices that conceal the true cost of care from purchasers and patients alike. There are also significant price differences between hospital-affiliated providers and independent physician offices. Hospital-owned facilities often charge significantly more by tacking on "facility fees" and other add-on costs that do not reflect clinical value.[10]

This lack of visibility allows hospitals to charge arbitrary and widely varying prices for routine services, while weakening employers' ability to compare providers, design affordable benefits, and negotiate lower prices. Together, this results in higher premiums, exposure to unexpected bills, and charges that employers and working families often cannot anticipate or challenge.

2 Consolidation fosters monopoly power and anticompetitive contracting practices

As dominant health systems acquire competitor hospitals, physician groups, and outpatient practices, they gain the leverage to raise prices, limit plan options, and steer patients toward higher-cost care settings, often without corresponding improvements in quality or patient outcomes. Over the past three decades, accelerating consolidation across the U.S. healthcare system has driven cost increases for employers and families.

Beyond pricing, consolidation reshapes how care is delivered. It shifts routine services into more expensive hospital-owned settings, while reducing access to independent providers is reduced, particularly in rural communities.

Hospital Monopolies by the Numbers:

- **Over 2,000 hospital mergers** have taken place over the past 30 years.[11]
- Today, **nearly 50% of U.S. metro areas** are dominated by a single hospital system, and **76% of markets** are highly or very highly concentrated.[12,13]
- Hospitals in **monopoly markets charge 12% more** than hospitals in competitive markets.[14]
- Between 2022 and 2024, **large hospital systems acquired 2,800 physician practices**, often converting them to hospital outpatient departments, where routine services can cost up to 58% more than in independent settings.[15]

Sutter Health: A Cautionary Tale on Consolidation

Over the course of the 2000s and 2010s, Sutter Health became the largest hospital system in Northern California, employing roughly 12,000 physicians across hospitals, surgery and cancer centers, and outpatient offices. Following a class action lawsuit filed by the United Food and Commercial Workers International Union health plan, the California Attorney General ultimately settled the case in 2019 – but not before Sutter used its monopoly power and anticompetitive contracting practices to drive up costs for working families across the state.[16]

3 Steep markups and lack of accountability for government benefits reinforce these incentives

Hospitals benefit from significant public subsidies, including drug discounts and tax exemptions. However, these supports are often poorly targeted and lack clear accountability. While employers strongly support safety-net care and the role hospitals play in serving vulnerable populations, these benefits should have transparency into how they are applied and translate into lower costs for patients and purchasers.

Half of American hospitals are nonprofits and therefore exempt from paying taxes; that includes some of the largest health systems in the U.S., such as CommonSpirit Health, Kaiser Permanente, Providence

Health, UC Health, and the Mayo Clinic.[17,18] Yet, there are few guardrails that ensure the value of forgone tax revenue for federal, state, and local governments translates into measurable community benefit. Some analyses suggest that eligible patients do not consistently receive charity care, though practices vary across institutions and regions.[19]

The 340B Drug Pricing Program illustrates how these challenges converge. While intended to support care for underserved populations, the program today reflects the combined effects of limited transparency, consolidation incentives, misaligned reimbursement structures, and a lack of accountability. Hospitals can purchase drugs at steep discounts, bill commercial health plans at much higher rates, and retain the difference, with no requirement to demonstrate that savings are passed on to patients or reduce costs for purchasers.[20]

As a result, 340B functions as a case study in how opaque public subsidies can reinforce broader market distortions. The program creates incentives for hospital systems to expand through acquisition in order to broaden their 340B footprint, including in well-insured areas. Research has also shown that some hospitals exploit loopholes in eligibility rules for 340B and other programs to receive benefits by qualifying as "rural" without meaningfully serving rural populations.[21] Evidence also suggests that 340B can increase spending by reducing negotiated rebates on 340B-purchased drugs and encouraging the use of higher-cost therapies over lower-cost alternatives such as biosimilars.[22,23]

Government Benefits and Drug Markups by the Numbers:

- Altogether, nonprofit hospitals receive an estimated **$36 billion in tax exemptions**.[24]
- Hospital **drug markups range from 118% to 663%** above acquisition cost for some oncology medications.[25]
- In 2024, 340B covered entities were reimbursed **$147.8 billion** for medicines purchased at a steep discount for $81.4 billion.[26]
- The total annual 340B spread paid by state employee health plans alone ranged from $2 million to $89 million in 2025 — or **roughly $1 billion** nationally.[27]

Groundbreaking Report Sheds Light on 340B Impact in Minnesota

Minnesota's first-in-the-nation 340B transparency reports represent the most robust accountability around 340B to date. They show that more than 80% of program revenue flowed to large hospital systems, with one large, consolidated hospital system receiving more revenue than all rural hospitals and community health centers combined. Nearly half of 340B revenue in the state, or over $600 million a year, came from the 340B "spread" paid by employers through the commercial market.[28]

Our Solutions:

A Practical Affordability Agenda for State and Federal Policymakers

Employers cannot solve these problems through negotiations and benefit design alone. Without policy reform, consolidated hospital markets with opaque pricing and misaligned financial incentives will continue to drive up costs faster than working families can absorb.

The following reforms respond directly to the core affordability challenges outlined above: a lack of transparency, anticompetitive consolidation, and insufficient accountability for public subsidies. State and federal policymakers should take steps to help employers rein in costs, not exacerbate them, by strengthening accountability.

1 Limit arbitrary and inflationary mark-ups: "Same service, same price"

To address the hidden costs and pricing distortions that undermine transparency and value-based purchasing, patients and employers should not pay more for the same service simply because it takes place in an office owned by a hospital system instead of an independent doctor. Site-neutral payment reform and the elimination of "facility fees" can reduce unnecessary hospital spending — which inflates premiums and increases out-of-pocket costs — while preserving access to care and ensuring that reimbursement reflects clinical value.

2 Promote competition and curb anticompetitive conduct

To address consolidation and the market power it gives dominant hospital systems, policymakers should scrutinize and prohibit hospital practices such as anti-tiering, anti-steering, all-or-nothing contracting, gag clauses, and similar restrictions.

Regulators should also strengthen antitrust and merger enforcement by closely reviewing hospital mergers, physician practice acquisitions, and cross-market expansion strategies that give large systems outsized pricing power over employers and communities. States should also examine laws and regulations that make it harder for new entrants, independent providers, and innovative care settings to compete on price and quality.

Competition policy should not only lower prices; it should also protect access, especially in rural and underserved communities that need sustainable, local, and lower-cost care options.

3 Ensure working families benefit from discounts and tax breaks

To help ensure that public subsidies and government benefits are functioning as intended and not exacerbating flawed incentives, hospitals receiving tax

exemptions and steep drug discounts should be accountable for meaningful community benefit, robust charity care, and responsible billing practices. Their special financial advantages should help lower costs for working families and expand access in rural and underserved areas, not increase revenue for large hospital systems.

Reforms should include standardized community benefit reporting, stronger charity care expectations, clear billing protections for eligible low-income patients, and government review of tax-exempt status when hospitals fail to meet those obligations.

Employers and unions also support efforts to improve reporting on how 340B revenue and nonprofit tax benefits are used — and to better understand how they affect working families and the healthcare system as a whole.

A Call to Action

Employers believe in strong hospitals, stable healthcare markets, and affordable coverage for working families. This requires a hospital market built on transparency and accountability — not opacity, unchecked market power, and misaligned incentives.

Public benefits for hospitals should be transparent and translate into lower costs for working families and real community benefits.

Reimbursement should reflect the service delivered, not who owns the facility.

Competition is needed to reduce the prices employers and families pay.

Employers are ready to work with state and federal policymakers on practical reforms that lower hospital costs, preserve access to care, and strengthen communities.

---

1 KFF
2 KFF
3 KFF
4 Baker Institute
5 Patient Rights Advocate
6 Patient Rights Advocate
7 National Alliance of Healthcare Purchaser Coalitions
8 National Alliance of Healthcare Purchaser Coalitions
9 Michigan Health Purchasers Coalition
10 Health Care Cost Institute
11 Bipartisan Policy Center
12 KFF
13 Health Care Cost Institute
14 Quarterly Journal of Economics
15 Physicians Advocacy Institute
16 California Office of the Attorney General
17 HHS Office of the Assistant Secretary for Planning and Evaluation
18 Definitive Healthcare, Hospital View
19 KFF Health News
20 National Alliance of Healthcare Purchaser Coalitions
21 National Grange
22 National Alliance of Healthcare Purchaser Coalitions
23 Congressional Budget Office
24 Lown Institute
25 JAMA Internal Medicine
26 Drug Channels Institute
27 IQVIA
28 Minnesota Department of Health