# The Hospital Cost Crisis

## How Government Policies Drive Consolidation, Undermine Competition, and Fuel Soaring Prices

John R. Graham

PARAGON HEALTH INSTITUTE

APRIL 2026

The author is grateful to Doug Badger, Brian Blase, Emma Gallutia, Lisa Grabert. Jackson Hammond, Mark Howell, David Johnson, Rushil Knagaram, Demetroius Kouzakas, Ryan Long, Gabrielle Minarik, Matt Robinson, and the Paragon team for their exceptional comments and work in review of the paper.

(703) 527-2734
paragoninstitute.org

# ABOUT THE AUTHOR

John R. Graham is a Visiting Fellow who contributes nearly three decades of health policy expertise to research across all of Paragon's initiatives. He worked on Capitol Hill from 2021 to 2024 as a Professional Staff Member on the Senate Special Committee on Aging and the House Committee on Ways & Means. From 2018 to 2021, he served as the U.S. Department of Health & Human Services (HHS) Regional Director for Region 10 (Washington State, Oregon, Idaho, and Alaska), where he managed relationships with state governments and the private sector. In 2017-2018, John was the HHS Acting Assistant Secretary for Planning & Evaluation.

Prior to HHS, John was Vice President at the Advanced Medical Technology Association. He has worked at health policy organizations including the National Center for Policy Analysis, the Independent Institute, the Mercatus Center, the Pacific Research Institute, and the Fraser Institute.

John was an infantry officer in the Canadian Army. He earned his B.A. from the Royal Military College of Canada, and his MBA from the London Business School in London, England.

# EXECUTIVE SUMMARY

## *What This Paper Covers*

Hospitals are the largest cost drivers in the U.S. health care system, accounting for about one-third of total expenditures. Government payments into this system are a primary driver of the nation's worsening fiscal outlook.[1] Given these realities, it is imperative that policymakers understand the role of modern hospitals, the development of giant health systems, and the incentives driving their business decisions. Unfortunately, hospital care in the United States does not reflect a well-functioning, dynamic market that provides efficient, cost-effective care. It is marked by opacity, complexity, and distorted prices.

In 2018, the Departments of Health and Human Services, Labor, and the Treasury conducted an important study that concluded that state and federal policies "have reduced incentives for price-and non-price competition, increased barriers to entry, promoted and allowed excessive consolidation, and resulted in healthcare markets that lack the benefits of vigorous competition."[2]

This paper examines how government policies — federal and state regulations, government payment programs, and direct subsidies — have reshaped the hospital sector. Rather than operating in a competitive market that rewards efficiency and value, hospitals increasingly function within a government-designed financing system that rewards consolidation, weakens accountability, and inflates prices.

## *What We Found*

- Hospital prices are soaring.
    - Since 2000, hospital prices have increased *three times faster* than inflation and *twice* as fast as wage growth. Hospital price inflation outpaces every other major sector of the U.S. economy.

1 Paul Winfree, "The Contribution of Federal Health Programs to U.S. Fiscal Challenges and the Need for Reform," Paragon Health Institute, January 2023, https://paragoninstitute.org/medicaid/post-the-contribution-of-federal-health-programs-to-us-fiscal-challenges-and-the-need-for-reform/.

2 U.S. Department of Health and Human Services, *Reforming America's Healthcare System Through Choice and Competition*, 2018, 16–17, https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

- Government policies and payments insulate hospitals from competition.
    - Certificate-of-need (CON) laws restrict competition by requiring government approval before new facilities or services can open.
    - The limitation on Medicare payment for new physician-owned hospitals prevents high-quality competitors from entering the market.
- Hospitals are insulated from consumer accountability.
    - Only a small share of hospital revenue (approximately 2 percent) comes directly from patients, weakening price sensitivity and competitive pressure.
- Technological advances have not improved productivity and led to lower expenditures.
    - Even as technology has advanced and reduced the need for inpatient care, hospital prices have continued to rise sharply.
- Hospitals are *not* broadly financially distressed.
    - Many hospitals operate with solid operating margins, substantial investment income, and extensive public subsidies — conditions inconsistent with an industry in financial distress.
    - In 2024, hospital operating profits averaged 6.4 percent, total margins reached 6.5 percent, and investment income contributed billions more.[3] Many hospitals have strong cash reserves and growing investment portfolios, but costs not associated with patient care have risen at the same rate as costs for patient care, indicating poor productivity.
    - Hospitals claim losses on government programs, but marginal profit on Medicare is consistently positive — 5–8 percent in recent years.
    - Even though Medicare pays only 40 percent as much as private insurers pay on average, more than half of hospitals make money on Medicare, and at least one-third make money on Medicaid.[4]

3 Medicare Payment Advisory Committee (MedPAC), *Medicare Payment Policy: Report to Congress*, March 2026, 76, https://www.medpac.gov/document/march-2026-report-to-the-congress-medicare-payment-policy/.

4 David Kendall and Darbin Wooford, "Tale of Two Hospitals: Why Some Hospitals Succeed and Others Do Not," Third Way, August 15, 2024, https://www.thirdway.org/report/tale-of-two-hospitals-why-some-hospitals-succeed-and-others-do-not.

- Profits from Medicaid are boosted by states using financing schemes that result in large amounts of federal funding going directly to hospital coffers.[5]

- Government programs incentivize inefficiency.

  - Because Medicare pays hospitals for overhead, which they can allocate across both inpatient and outpatient settings, hospitals have less incentive to cut costs. Hospitals with high overhead and poor productivity often receive the same funding as — or in some cases, even more funding than — efficient, high-performing systems.
  - When supplemental and directed payments are included, Medicaid payments to hospitals often meet or exceed Medicare rates.
  - Two-thirds of hospital spending is now on costs not related to patient care — double that spent on patient care.[6] Narrower measures of administrative costs indicate that hospitals have not become more efficient in decades.[7]

- Government-driven consolidation reduces competition and increases prices.

  - Medicare pays significantly more when the same service is delivered in a hospital-owned outpatient department rather than a physician's office or ambulatory surgical center (ASC). This incentivizes hospitals to acquire physician practices and ASCs to then extract higher fees by taking advantage of this difference.
  - Hospitals are also using the 340B drug program as a way to earn unintended profits as well as a reason to buy up doctors' practices that are 340B-covered entities.
  - In recent years, hospitals have become massively integrated "health systems," with both horizontal and vertical integration.

5 Brian Blase and Niklas Kleinworth, "Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform," Paragon Health Institute, March 2025, https://paragoninstitute.org/medicaid/addressing-medicaid-money-laundering-the-lack-of-integrity-with-medicaid-financing-and-the-need-for-reform/.

6 Katie Patton and Allison Oakes, "Hospital Administrative Expenditures Exceed Direct Patient Care by Nearly 2x," Trilliant Health, October 17, 2025, https://www.trillianthealth.com/market-research/studies/hospital-administrative-expenditures-exceed-direct-patient-care-by-nearly-2x.

7 Noah S. Kalman et al., "Hospital Overhead Costs: The Neglected Driver of Health Care Spending?," *Journal of Health Care Finance* 41, no. 14 (2015), https://www.researchgate.net/publication/282921796_Hospital_overhead_costs_The_neglected_driver_of_health_care_spending; Lauree Handlon et al., "Trends in Hospital Administrative Costs: Urban-Rural Disparities, Barriers, and Reduction Strategies," *Health Affairs Scholar* 3, no. 8 (2025): qxaf149, https://doi.org/10.1093/haschl/qxaf149.

- In 2012, just 26 percent of physicians were employed by hospitals. By 2024, more than 55 percent of physicians were hospital employees.[8] And that trend shows no sign of slowing.
- The open-ended nature of federal health care spending has led to poorly designed laws that broadly limit the freedom of physicians to refer and collaborate. However, there are exceptions for employment. In this way, government policy favors consolidation while undermining physicians' ability to lead their own accountable care organizations. The result of this government-driven consolidation for patients is less choice and rising costs without any corresponding improvement in quality.
- When driven by government incentives such as higher payment, both vertical consolidation (hospitals acquiring surgical centers or physician practices) and horizontal consolidation (hospital mergers into larger systems) increase prices.
- Because bloated government payments have created an overly costly and uncompetitive hospital system, employers and other private payers are unable to negotiate better prices.

- Hospital subsidies are extensive, opaque, and poorly targeted.

  - Hospitals benefit from hundreds of billions of dollars annually in government spending. There are several direct subsidy programs, all of which push up hospital prices and spending, such as:

    - Medicare and Medicaid payments, including numerous direct subsidy programs to hospitals within each, such as graduate medical education (GME);
    - provider taxes, supplemental payments, and state-directed payments (SDPs), which have increasingly turned Medicaid financing into vehicles for large federal payments to hospitals;
    - Affordable Care Act premium tax credits and tax-advantaged employer-sponsored health spending, which lead to additional resources flowing to hospitals; and
    - 340B drug discount windfalls, which flow predominantly to wealthier, tax-exempt entities.

8 Avalere Health, "Updated Report: Hospitals and Corporate Acquisition of Physician Practices and Physician Employment 2019–2023," Physicians Advocacy Institute, April 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf.

- Government expenditures are rarely tied to competition for consumers, performance, efficiency, or financial need.

- Hospitals can be more efficient, and reformed government programs should be aimed at incentivizing hospital productivity and cost-efficiency.

  - Many hospitals deliver high-quality care while operating efficiently under existing payment levels, demonstrating that cost control and quality improvement are compatible — and that higher subsidies are not a prerequisite for good outcomes.
  - Some hospitals succeed while serving large numbers of Medicare and Medicaid enrollees. These high-performing hospitals embrace efficiency, controlling labor and administrative costs while delivering more charity care than many well-subsidized tax-exempt peers.
  - Despite the industry's claims, many hospitals can and do respond to pressure to contain costs by becoming more efficient.

## *Why It Matters*

Americans spend more than $1.6 trillion annually at hospitals — roughly one-third of health spending. Hospital spending is also a major driver of federal and state fiscal pressures, particularly through Medicare and Medicaid. Despite this staggering cost, the public and most policymakers — and in many cases hospitals themselves — have little insight into how hospitals spend, allocate cost, or profit.

For many Americans, hospitalization is not only a medical crisis but also a financial one. Despite extensive subsidies and insurance coverage, patients face high and unpredictable costs, and many delay or forgo care because of financial concerns. At the same time, taxpayers fund a system that lacks transparency, rewards inefficiency, and delivers inconsistent value.

A recent survey showed that 32 percent of Americans have postponed surgery because of concerns about cost.[9] Half of Americans fear bankruptcy due to a major health event.[10] Medical debt is significantly associated with untreated mental illness: One-third of people

9 Discover, "Survey by Discover Personal Loans Reveals Medical Debt's Impact on Consumers' Stress Levels and Wa," February 1, 2024, https://web.archive.org/web/20241115172953/https:/investorrelations.discover.com/newsroom/blog/Survey-by-Discover-Personal-Loans-Reveals-Medical-Debts--Impact-on-Consumers-Stress-Levels-and-Wallets/.

10 Dan Witters, "50% in U.S. Fear Bankruptcy Due to Major Health Event," Gallup, September 1, 2020, https://news.gallup.com/poll/317948/fear-bankruptcy-due-major-health-event.aspx.

suffering mental illness who have medical debt forgo treatment (versus only 6 percent of those without medical debt).[11]

Government regulation has also resulted in distortions and complexity. A clear pattern has emerged in public data over the past three decades: Government policies have inflated prices, rewarded inefficiency, and distorted the health care marketplace. Nowhere is this pattern felt more keenly than in U.S. hospitals — as the largest U.S. hospital systems have responded vigorously to intended and unintended government incentives and by devoting ever-increasing resources to lobbying. From 2000 through 2020, providers (including hospitals) increased spending on federal lobbying alone by 70 percent in real, inflation-adjusted dollars.[12] In the first three quarters of 2025, hospitals and nursing homes increased lobbying spending by 20 percent from the previous year.[13]

If federal and state lawmakers want to lower health costs, improve outcomes, and create market discipline, they should start with recognizing how government policies inflate and distort hospital prices while incentivizing consolidation. Understanding how subsidies, government support, and regulatory protections undermine competition and create disincentives for hospitals to be efficient, minimize costs, and continually innovate will help inform policy alternatives that can encourage competition, improve accountability, and increase cost-effective patient care. Nothing short of serious reform will fix the deeply embedded incentives that fuel rising prices, suppress competition, and undermine transparency in the hospital market.

## *What We Recommend*

The key to reforming hospital financing is reversing or mitigating government policies that inflate costs, prices, and spending without accountability to patients. It means targeting subsidies based on need, rewarding efficiency, and reforming structural market distortions while eliminating policies that are driving consolidation. Policymakers can take 12 steps to radically improve upon the status quo:

1. Congress should enact site-neutral payment reform in Medicare so that the same payment is made regardless of setting. The Centers for Medicare and Medicaid Services (CMS) should build off its recent actions and use its administrative authorities to advance site-neutral payment

11 Kyle J. Moon et al., "Medical Debt and Forgone Mental Health Care Due to Cost Among Adults," *JAMA Health Forum* 6, no. 4 (2025): e250383, https://doi.org/10.1001/jamahealthforum.2025.0383.

12 William L. Schpero et al., "Lobbying Expenditures in the US Health Care Sector, 2000–2020," *JAMA Health Forum* 3, no. 10 (2022): e223801, https://doi.org/10.1001/jamahealthforum.2022.3801.

13 Michael McAuliff, "Healthcare Lobbying Surged in 2025," *Modern Healthcare*, December 4, 2025, http://www.modernhealthcare.com/politics-regulation/mh-healthcare-lobbying-2025-phrma-aha/.

reforms, as described in a recent Paragon policy brief.[14] States should advance site-neutral payment reforms in Medicaid. Site-neutral reforms would reduce consolidation incentives, strengthen the program for the future, and deliver savings for seniors and taxpayers.

2. CMS should consider modernizing rate setting using Medicare Advantage price transparency data — which is now required to be publicly disclosed — as a proxy for cost and resource use when setting rates or the relativity of rates within the Physician Fee Schedule and hospital outpatient payment systems.[15]
3. Congress should limit Medicaid financing gimmicks that inflate hospital payments and increase federal spending, building on the important reforms in the One Big Beautiful Bill Act that reduced states' ability to use the provider tax scheme and capped Medicaid payment through SDPs at or near Medicare levels. CMS should reject state efforts to increase their use of money laundering tactics to inflate payments to hospital systems. And states should resist pressure from hospital systems to create workarounds to federal law that attempt to gain more federal Medicaid money for their coffers.
4. CMS should conduct better oversight of supplemental payments for hospitals, including Disproportionate Share Hospital payments, to inform policymakers on how to rationalize the disparate hospital subsidy streams into a more targeted, sensible structure where funds flow to true safety-net providers. Congress should then enact such reforms.
5. Congress should direct the Government Accountability Office to compile an inventory of all federal hospital payments, including subsidy programs, and provide recommendations on how to simplify and focus overlapping programs and condition future payments and subsidies on quality, efficiency, and financial transparency. Congress should then enact such reforms.
6. Congress and the Trump administration should address distortions in the 340B program by targeting dollars to entities or directly to individuals, in either case based on their need, reducing incentives for consolidation and saving consumers and taxpayer dollars.
7. States should remove regulatory barriers to competition, including by repealing or limiting CON laws. Congress and the administration can

14 Demetrios L. Kouzoukas and Jackson Hammond, "Advancing Choice, Competition, and Fiscal Sustainability in Medicare: A Roadmap for CMS," Paragon Health Institute, February 11, 2026, https://paragoninstitute.org/medicare/advancing-choice-competition-and-fiscal-sustainability-in-medicare-a-roadmap-for-cms/.

15 Kouzoukas and Hammond, "Advancing Choice, Competition, and Fiscal Sustainability in Medicare."

encourage this by conditioning federal money on positive reforms. For example, the Rural Health Transformation Fund awards points to states without CON laws, increasing their potential funding.[16]

8. Congress should repeal the Medicare payment limitations on physician-owned hospitals included in the Affordable Care Act.
9. In the short term, Congress and the administration should increase oversight of hospitals' compliance with IRS rules. Longer term, Congress should tie tax-exempt status to measurable and actual charity care instead of vaguely defined "community benefit."
10. The federal government should enforce price transparency requirements on both hospital systems and insurers.
11. Congress should remove uncompensated care payments from Medicare, index them to inflation, and base them on a hospital's share of charity care and non-Medicare bad debt.[17]
12. Congress should eliminate GME funding by formula, replacing it with discretionary grants to support residents' education, not hospitals' revenues.

16 Bill Finerfrock, "Rural Health Transformation Fund Offers States a Way to Improve Rural Health Care Access: Here's What States Should Do," Paragon Health Institute, October 2025, https://paragoninstitute.org/medicaid/rural-health-transformation-fund-offers-states-a-way-to-improve-rural-health-care-access-heres-what-states-should-do/.

17 Jackson Hammond, "Medicare Reforms for Reconciliation," Paragon Health Institute, April 30, 2025, https://paragoninstitute.org/medicare/medicare-reforms-for-reconciliation/.

# INTRODUCTION: HOSPITAL SPENDING IS DRIVING AMERICA'S HEALTH CARE COST CRISIS

The word *hospital* traditionally called to mind a single building in the local community dedicated to short-term acute care where patients were admitted for treatment or observation. In recent decades, however, America's hospitals have grown into huge "health systems." Such health systems increasingly dominate and select the supply of both inpatient and outpatient care available in the area.

For this paper, we use the word *hospital* to refer to these large health systems, because that is the word used by their trade associations — the American Hospital Association (AHA, which includes tax-exempt and tax-paying hospitals) and the Federation of American Hospitals (which includes tax-paying hospitals). Nearly two-thirds of general community hospitals (65 percent) benefit from tax-exempt status, and some of the discussion in this paper applies specifically to them.[18]

Today, a single hospital that operates independently is increasingly rare in the United States. Instead, modern hospitals now own outpatient facilities and physician practices apart from their main campuses, with branding throughout the region and often with corporate ownership that spans multiple states. Furthermore, since the federal government seized the commanding heights of hospital payment with the establishment of Medicare and Medicaid in 1965, federal regulations describe many categories of "hospital," primarily to determine eligibility for the ever-increasing web of government programs that spend money on hospitals.

Whether a single building or a vast health system, the current and future role of hospitals is critical to America's future. Health care in the United States is unsustainably expensive, and hospitals are the largest — and most rapidly growing — component of that cost. In 1970, health spending accounted for only 6.9 percent of gross domestic product (GDP).[19] That share has increased more than 2.5 times, reaching 18.0 percent in 2024.[20] Yet the quality delivered in return for this unprecedented spending is inconsistent and difficult to assess and does not represent enough value for the expense.

The primary driver of this cost explosion is America's hospitals' response to government incentives.

18 Zachary Levinson et al., "Key Facts About Hospitals," KFF, February 19, 2025, https://www.kff.org/key-facts-about-hospitals/.

19 Matthew McGough et al., "How Has U.S. Spending on Healthcare Changed over Time?," Peterson-KFF Health System Tracker, December 20, 2024, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/.

20 Micah Hartman et al., "National Health Care Spending Increased 7.2 Percent In 2024 as Utilization Remained Elevated: Article Examines National Health Care Spending in 2024," *Health Affairs* 45, no. 2 (January 14, 2026), https://doi.org/10.1377/hlthaff.2025.01683.

In 2024, Americans spent over $1.6 trillion on hospital care, more than the total GDP of Spain.[21] Hospitals now account for nearly one-third of national health expenditures, reinforced by a lobbying budget that exceeded $115 million in 2025 that is a logical consequence, if not necessity, of the government's dominant role.[22] Yet, instead of becoming more productive or competing to reduce costs in a competitive marketplace, hospitals operate in a regulatory and financial environment that distorts incentives, rewards consolidation, and shields — if not outright encourages — inefficiency.

Medicare and Medicaid (as well as private insurers, as they typically follow these two dominant government payers) use legacy payment formulas and administrative pricing systems detached from patient outcomes, competition, and value. These systems were designed to reimburse the cost of items and services — not outcomes — and often reward hospitals more when they deliver high-cost care, not better care.

This paper is divided into eight parts:

- Part 1 describes how hospital prices have dramatically outpaced overall inflation, wages, and prices of other medical care services.
- Part 2 examines how hospitals are paid by Medicare and Medicaid, revealing that hospitals operate with positive profits and large investment returns despite often claiming that they lose money.
- Part 3 examines the shift from inpatient care to outpatient care, which should have reduced total hospitalization costs but has not, because hospitals have blocked policies that would reduce spending.
- Part 4 explores the wide range of government programs and subsidies that benefit hospitals.
- Part 5 looks at how those programs and subsidies lead to abuse, undermine competition, and distort decision-making.
- Part 6 examines how those programs and subsidies lead to greater inefficiency, increase overhead, and raise administrative costs.
- Part 7 profiles high-performing systems that compete on value and succeed under current rules, which should establish a benchmark for policy, and debunks common talking points hospitals deploy to oppose reforms.
- Part 8 concludes with recommendations that would reform government programs that have contributed to hospital price inflation and are aimed at

21 Levinson et al., "Key Facts About Hospitals."

22 OpenSecrets, "Hospitals/Nursing Homes Lobbying Profile," February 19, 2025, https://www.opensecrets.org/federal-lobbying/industries/summary?id=H02.

improving hospital quality and productivity while deterring further government-driven consolidation.

# PART 1: HOSPITAL PRICE INFLATION

## Hospital Prices Have Exploded

Hospital prices have not merely risen in recent years — they have exploded. Figure 1, created by Professor Mark Perry, shows price changes for several goods and services from 2000 through 2025. By *prices*, we refer to the amount that is actually paid for the service or, equivalently, the amount received by the provider. In health care, the price paid is often very different from the amount charged or the list price because of so much "discounting" by third parties and because the price charged is often ridiculously high. Over this quarter century, prices for hospital services increased by 281 percent — far outstripping price increases for housing, child care, and even college tuition. Prices of hospital services surged more than three times overall inflation (93 percent), as measured by the Consumer Price Index (CPI). By comparison, private sector hourly wages over this period increased 39 percentage points more than the CPI did, but it was not remotely close to the price changes in hospital services, which rose more than twice as much as wages.

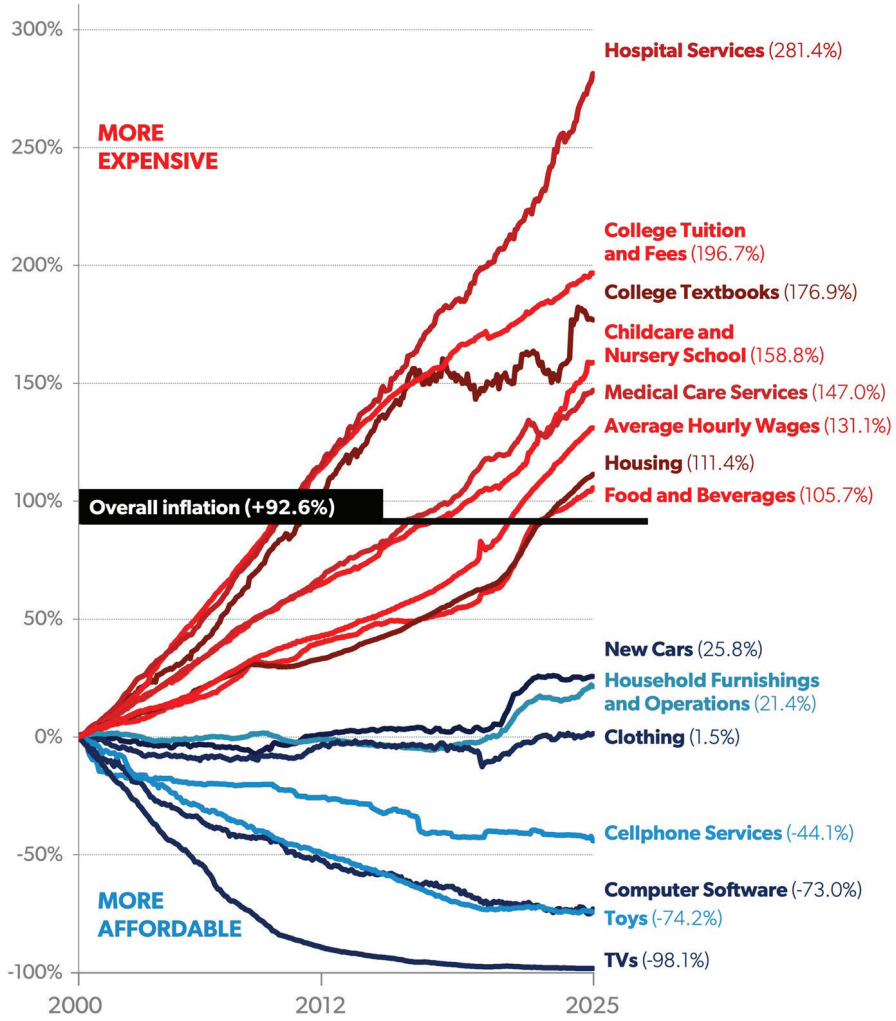
Looking closely at this data reveals that the goods and services that declined relative to average hourly wages were connected to technology and manufacturing and were less subject to government regulation and subsidies. These areas were subject to some of the most competitive market forces in the world, whereas the areas where prices increased most significantly — health care and education — were subject to extensive government control, support, and subsidy.

Nevertheless, there is more to the story: The prices of medical care services, which include hospital services, grew by only 147 percent, meaning that other medical services grew much less than hospital-based services did. In fact, there are areas of health care that have had low price changes. For example, the price of elective LASIK surgery has gone down relative to inflation since 2000. These overall trends point to the indisputable fact that America's health care cost crisis is heavily concentrated in the hospital sector.

## Supply-Side Restrictions Lead to Higher Hospital Prices

Much of the stratospheric rise in prices in the hospital sector can be understood by applying the most elementary principles of economics: supply and demand. Prices rise because of some combination of growing demand and falling supply. Falling supply — from government-imposed supply restrictions and government-driven market consolidation — is the prime driver

## Figure 1: Price Changes (Jan. 2000–Dec. 2025) Selected U.S. Consumer Goods and Services, and Wages




SOURCE: Mark J. Perry (@Mark_J_Perry), "'Chart of the Century' updated through December 2025," X, January 25, 2026, https://x.com/Mark_J_Perry/status/2015463505298878746.

NOTE: The CPI for "medical care" weight uses out-of-pocket spending including enrollees' share of premium and excluding employers' or taxpayers' share of premium. However, the price changes for the components of medical care are from both out-of-pocket and third-party payments from commercial plans, and Medicare Parts B, C and D. CPI "medical care" disregards Medicaid, worker's compensation, and other instances without consumer payment. These payments are included in the Producer Price Index.

behind the two decades of price increases along with continued and increasing government subsidies that advantage hospitals — particularly larger existing ones. When government subsidizes hospitals, it frees them from the need to control costs or discipline their prices, especially when the subsidies are inherently inflationary, including by virtue of being based on costs.

## Certificate-of-Need Laws

Certificate-of-need (CON) laws are one of the most harmful supply restrictions and key drivers of consolidation. CON laws were originally intended to prevent overbuilding of hospitals, and the federal government required states to implement them in the 1980s. Although Congress has long since eliminated this requirement, 26 states and the District of Columbia maintain CON laws for general hospitals.[23] Hospitals lobby states to maintain CON laws, using them to block new entrants and competition they would otherwise face.

CON laws tilt the playing field by protecting incumbents, restricting entry, and leading to limited access, lower quality, and higher costs.[24] For hospitals — especially large hospital systems — CON laws translate into more pricing power and leverage over the markets they dominate. Unfortunately for patients, CON laws mean fewer options in these non-competitive markets, less specialization, and less innovation.

Although the federal government no longer has a CON law, it can influence states to repeal them as it had influenced states to enact them. The Trump administration has recently taken a small step in this direction by using state CON laws as a factor in awarding points for Rural Health Transformation Fund grants.[25]

## Physician-Owned Hospitals

Because of government-imposed rules and protections, incumbent hospitals are also protected from competition in other ways. For example, it has become increasingly difficult — if not practically impossible — for physicians to organize and establish their own hospitals to meet patient needs.

In the first decade of the 21st century, the growth of physician-owned hospitals stood out against consolidation among legacy hospitals. From just 67 at the turn of the 21st century, the number of physician-owned hospitals grew to 250 by 2010.

In 2010, lobbyists for both tax-exempt and tax-paying hospitals won a significant victory against competition from physician-owned hospitals. The Affordable Care Act (ACA) prohibited Medicare payments for new physician-owned hospitals, essentially freezing their continued growth.[26] This government restriction of competition hurts patients and taxpayers.

23 Radney Rakotoniaina and Johanna Butler, "50-State Scan of State Certificate-of-Need Programs," National Academy for State Health Policy State Tracker, December 10, 2025, https://nashp.org/state-tracker/50-state-scan-of-state-certificate-of-need-programs/.

24 Matthew D. Mitchell, "Certificate-of-Need Laws: How They Affect Healthcare Access, Quality, and Cost," Mercatus Center, May 21, 2021, https://www.mercatus.org/economic-insights/features/certificate-need-laws-how-they-affect-healthcare-access-quality-and-cost.

25 Finerfrock, "Rural Health Transformation Fund."

26 Michael Mandelberg et al., "Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation," *NYU Journal of Legislation and Public Policy* 26, no. 3 (2023): 697–767, https://doi.org/10.2139/ssrn.4350105.

Studies find that physician-owned hospitals outperform legacy hospitals with lower or comparable costs, less intensive use of procedures, and lower in-hospital and 30-day mortality.[27]

## Demand for Hospital Services

### Technological Change and Consumer Preference

Supply restrictions — the direct result of government policies — help explain some of the rise in hospital prices and costs. But according to the basic laws of economics, falling demand should mean *downward* pressure on prices. In the case of hospitals, however, prices have *risen* over this period even as demand has decreased.

In 1975, the nation had 941,844 community hospital beds.[28] The number declined to 674,000 by 2024 — a drop of 28 percent over the period.[29] At the same time, the U.S. population grew from about 216 million to 335 million people.[30] The net effect is a 54 percent reduction in beds per capita.

This reduction is largely because technology has allowed many medical procedures to move from the inpatient hospital to outpatient settings. Few people ever want to be admitted to a hospital unless it is strictly necessary. As technology advances, this shift will likely continue if not accelerate. One recent innovation is illustrative of this trend: mobile anesthesiology.

Mobile anesthesiology services transport portable anesthesia machines with all the standard monitoring equipment, airway management supplies, anesthesia medications, emergency medications for advanced cardiopulmonary life support and malignant hyperthermia, pediatric-related equipment, and anesthesia electronic medical record documentation. This allows a specialist to perform procedures in the office on patients for whom a hospital admission would previously have been necessary.[31]

In theory, such technological advances should drive hospital prices down as innovation becomes more widespread and hospitals seek to compete with lower-cost facilities. Instead, prices have risen steeply. So, clearly, there must be reasons why the hospital sector is defying

27 Brian J. Miller et al., "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review," Mercatus Center, September 7, 2021, https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.

28 Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2017: With Special Feature on Mortality* (2018), Table 89, http://www.ncbi.nlm.nih.gov/books/NBK532685/.

29 MedPAC, *Medicare Payment Policy*, March 2026, 64.

30 Federal Reserve Bank of St. Louis, "Population, Total for United States," July 2, 2024, https://fred.stlouisfed.org/series/POPTOTUSA647NWDB.

31 Steven Young et al., "Safety Considerations with the Current Ambulatory Trends: More Complicated Procedures and More Complicated Patients," *Korean Journal of Anesthesiology* 76, no. 5 (2023): 400–412.

the gains from innovation that characterize innumerable goods and services in our modern, competitive economy.

### Government Policies Lead to Higher Hospital Prices

Despite advancing technology and consumer preferences moving care out of inpatient hospital settings, other forces are putting upward pressure on hospital prices. By government design, most payment for health services is processed either directly by the government or through third parties. The size and scope of the government programs influence private sector negotiations because of government-driven expenditures, infrastructure, and expectations. In addition, third parties often use prices fixed by government, as opposed to prices set under normal market forces. Government subsidizes these third-party payers, directly or indirectly, through many programs and policies.

Medicare, Medicaid, and the ACA are designed to minimize the share of health spending controlled directly by patients: Subsidies flow directly to health insurers. Employer-based health insurance is designed such that when third parties pay, the benefits are exempt from individuals' taxable income. Even in consumer-directed health plans (also called high-deductible health plans), patients admitted to hospitals will incur costs much higher than their deductibles — making them virtually insensitive to hospital prices.

As a result, *only 2 percent of hospital revenue* comes directly from patients.[32] This lack of consumer direct payment in favor of subsidies to third parties removes the pressure on health providers to put patients first and keep prices in check.

## PART 2: WHAT WE KNOW ABOUT HOSPITAL FINANCES

### Private Health Insurance Is the Largest Share of Hospital Spending

In 2024, spending on hospitals amounted to $1.6 trillion, for both inpatient and outpatient services, representing nearly one third of national health expenditures. Private health insurance accounted for 34 percent of hospital spending, while government spending accounted for the rest. Medicare accounted for 27 percent, Medicaid 20 percent, other programs (including Children's Health Insurance Program, Department of Defense, Veterans Affairs and worker's compensation) accounted for 17 percent, and out-of-pocket payments made up only 2 percent.[33]

32 Centers for Medicare and Medicaid Services (CMS), "NHE Fact Sheet," January 14, 2026, Table 7, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

33 CMS, "NHE Fact Sheet," Table 7.

Private insurers pay hospitals significantly higher rates than Medicare does. A 2024 RAND study of all hospital inpatient and outpatient services found that employers and private insurers paid, on average, 254 percent of what Medicare would have paid for the same services at the same facilities in 2022.[34]

The spread between private and government rates has raised a "cost shift" theory. Under this theory, hospitals must increase prices charged to private payers because Medicare and Medicaid pay so little. However, this argument lacks both a compelling theory and evidence.[35]

If Medicare or Medicaid rates increased significantly, that would not incentivize hospitals to reduce rates to private payers. Rather, like any supplier, hospitals would continue to segment their customers and maximize profit from each segment — one segment is not charged more to "make up" for another charging less. In a competitive market, downward pressure on prices is the result of competition among providers, not because government controls demand.

Commercial rates tend to follow the trend in Medicare rates, in part because, for the reasons outlined above, commercial payers tend to link their payments to percentages of Medicare rates. For example, a 10 percent reduction in Medicare payment is associated with a 7.7 percent reduction in private rates.[36] Furthermore, when states set Medicaid payment rates as a function of average commercial rates (an emerging trend over the past several years), it encourages providers to increase commercial rates to secure higher Medicaid payments.[37]

The proportion of Americans covered by private insurance has declined. Some of this is due to the baby boomers aging into Medicare. Another factor is the expansion of Medicaid, the welfare program that pays for health care and long-term care services for generally lower-income Americans. As Medicaid enrollment grows, enrollment in private insurance contracts. From 2009 to 2019, the crowd-out rate was 43 percent.[38] That is, for every 100 people gaining Medicaid enrollment, 43 of them replaced private health insurance. Until the recent explosion of Medicaid rates for hospitals, this crowd-out meant that hospitals were losing customers with better-paid plans, as private insurers had much higher rates than Medicaid.

34 Christopher M. Whaley et al., "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative," RAND, December 10, 2024, https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

35 Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*, January 20, 2022, https://www.cbo.gov/publication/57422; Austin B. Frakt, "The End of Hospital Cost Shifting and the Quest for Hospital Productivity," *Health Services Research* 49, no. 1 (2014): 1–10, https://doi.org/10.1111/1475-6773.12105.

36 Chapin White, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," *Health Affairs* 32, no. 5 (2013): 935–943, https://doi.org/10.1377/hlthaff.2012.0332; Frakt, "The End of Hospital Cost Shifting."

37 Blase and Kleinworth, "Addressing Medicaid Money Laundering," 27.

38 Conor Lennon, "Did the Affordable Care Act's Medicaid Eligibility Expansions Crowd Out Private Health Insurance Coverage?," *Journal of Policy Analysis and Management* 44, no. 1 (2025): 208–235, https://doi.org/10.1002/pam.22556.

## Medicare Deeply Influences Hospitals

Medicare pays for hospital services in multiple ways.

First, there is fee-for-service (FFS, or "traditional") Medicare, where the government pays for each service directly. It consists of Part A for inpatient care and Part B for outpatient care. There is also Medicare Advantage (MA), which provides Part A and Part B benefits to enrollees through privately administered health plans that receive payment from the government. These plans are free to negotiate different fees with providers, but evidence suggests that fees paid to hospitals and physicians cluster closely around the FFS amounts.[39] Of all inpatient days, 24 percent were covered by traditional Medicare Part A, and 24 percent were covered by MA plans.[40] Although Medicare accounted for only 25 percent of hospitals' revenues in 2023, it accounted for 46 percent of discharges for inpatient services and 48 percent of inpatient days.[41] The size and scope of this government-paid segment strongly influences most hospitals, shaping the composition of services and the delivery infrastructure.

## Traditional Fee-for-Service Medicare: Payment Systems

Most Medicare beneficiaries are enrolled in both Medicare Part A (for inpatient services) and Part B (for outpatient and physician services). Medicare pays hospitals through administratively set payment systems that determine prices based on historical cost structures rather than competition or patient value. Although labeled "prospective," these systems remain closely tied to reported hospital costs and volumes, embedding inefficiency into payment updates and shaping hospital behavior within and across inpatient and outpatient settings.

The Centers for Medicare and Medicaid Services (CMS) provides annual updates to these payment systems using a non-budget-neutral "market basket," which adjusts prices for different expenditures and determines their weights in the basket with an adjustment for "productivity," discussed below.[42]

Another relevant Medicare payment system is the Physician Fee Schedule (PFS). Medicare originally paid for physician services and related items on the basis of usual and customary charges. The PFS replaced these charges, creating a set of about 8,000 codes and payments

39 Daria M. Pelech, "Prices for Physicians' Services in Medicare Advantage and Commercial Plans," *Medical Care Research and Review* 77, no. 3 (2020): 236–248, https://doi.org/10.1177/1077558718780604; Jared Lane K. Maeda and Lyle Nelson, "How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare with Medicare Fee-for-Service Prices?," *Inquiry* 55 (June 2018): 0046958018779654, https://doi.org/10.1177/0046958018779654.

40 Levinson et al., "Key Facts About Hospitals," Figure 24.

41 Levinson et al., "Key Facts About Hospitals," Figure 23.

42 Centers for Medicare and Medicaid Services, "FAQ — Market Basket Definitions and General Information," September 2023, www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf.

for distinct items and services. The codes were the result of a bureaucratic process that attempted to account for the resources involved, including physician work, practice expenses, and professional liability insurance.[43] Although the PFS was designed for physicians and not hospitals, PFS revenue is still important to hospital finances because when hospitals employ physicians, physicians will often assign the PFS payments to the hospital, which then can also charge additional facility fees.

## Medicaid Spending on Hospitals Shows Wide Variance

Medicaid comprised 20 percent of hospitals' revenues in 2024.[44] The program operates through an FFS model and through managed care plans.

On average, Medicaid FFS *base* payments are below Medicare payment rates for comparable services — although there is wide variance among the states. Many states have higher Medicaid rates than Medicare rates when Medicaid supplemental payments are factored in. These supplemental payments, discussed below, comprise a mix of overlapping subsidies that Congress and states have employed over the years to patch problems that hospitals raise with Medicaid payments.

The wide variance at the state level is best seen in Medicaid inpatient base rates. These rates are the foundational payment amounts that state Medicaid programs use to reimburse hospitals for inpatient services in FFS arrangements. In 2010, Medicaid inpatient base rates ranged from 49 percent to 169 percent of the national average for Medicare rates. Of the 48 states (and DC) analyzed, Medicaid base rates were lower than Medicare in 28 states and higher in 20.[45]

Medicaid FFS base-payment rates were 78 percent of Medicare for 18 types of inpatient services studied.[46] However, these estimates are 15 years old and prior to major policy developments that have significantly increased Medicaid payments, particularly the growth of state-directed payments (SDPs).[47] According to a 2017 analysis, when including supplemental payments, Medicaid payment rates *exceeded* Medicare's by 6 percent for 18 diagnosis-related groups based on 2010–2012 Medicaid data and 2011 Medicare data — well before the growth

43 MedPAC, "Physician and Other Health Professional Payment System," revised October 2024, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf.

44 CMS, "NHE Fact Sheet," Table 7.

45 Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid Hospital Payment: A Comparison Across States and to Medicare," April 2017, https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

46 MACPAC, "Medicaid Hospital Payment," cited in MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," May 2024, 4, https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/.

47 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

## Table 1: Supplemental Payments and State Directed Payments Were 40 Percent of Total Medicaid Spending Received by Hospitals

| Payment Category | Share of Total Medicaid Hospital Payments (%) |
|---|---|
| Managed Care Base Payments | 41% |
| Managed Care Directed Payments | 20% |
| Fee-for-Service (FFS) Base Payments | 19% |
| Supplemental Payments (FFS) | 20% |

SOURCE: Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid Base and Supplemental Payments to Hospitals," April 2024. https://www.macpac.gov/wp-content/uploads/2024/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

in SDPs.[48] Although Medicaid base-payment rates are often below Medicare rates, total Medicaid payments — including supplemental and SDPs — now exceed Medicare rates.[49] Fortunately, this trend is likely to diminish because of reforms in the One Big Beautiful Bill Act (OBBB) that tamp down on states' ability to engage in these schemes.[50]

In considering the impact of Medicaid on hospitals, it is important to note that many prior estimates excluded Medicaid managed care plans. These plans now cover 74 percent of Medicaid enrollees and are subsidized by supplemental payments and SDPs.[51] SDPs are financed mostly by exploiting the structure of the state-federal relationship in Medicaid. States use revenue-maximization financing schemes to require plans to pay much higher rates — rates that now approach average commercial rates in many states.[52]

In 2022, managed-care base payments accounted for 41 percent of hospitals' Medicaid revenue, managed-care directed payments 20 percent, FFS base payments 19 percent, and supplemental payments 20 percent, as displayed in Table 1.[53]

48 MACPAC, "Medicaid Hospital Payment."

49 Blase and Kleinworth, "Addressing Medicaid Money Laundering"; MACPAC, "Medicaid Hospital Payment."

50 Brian Blase, "Debunking the Myths of the One Big Beautiful Bill," Paragon Health Institute, July 25, 2025, https://paragoninstitute.org/medicaid/myth-states-will-not-be-able-to-cope-with-the-limits-on-medicaid-money-laundering-mechanisms/.

51 MACPAC, "Exhibit 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group," February 2026, https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/.

52 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

53 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," April 2024, https://www.macpac.gov/wp-content/uploads/2024/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

## The Role of Medicare Cost Reports and Their Limitations

### Medicare Cost Reports

The most widely used and publicly available reports for analyzing hospitals' costs are the Medicare Cost Reports (MCRs), which hospitals submit to CMS and which CMS publishes as a public data file.[54] These reports are important because CMS uses them, in addition to a base rate and market basket, as the primary input in deciding how much to pay hospitals for inpatient and outpatient procedures. Also, MCRs are the only national data available for all types of providers.[55]

Hospitals report their costs annually to CMS in four broad categories: allowable costs, allocation of overhead costs, ratio of cost to charges, and Medicare's share of allowable costs. The worksheets crosswalk costs in hospital departments to Medicare cost centers (i.e., more specific categories, also known as "lines"). These "lines" include general service (e.g., housekeeping or plant operations), inpatient routine costs (e.g., surgery or intensive care unit), outpatient routine costs (e.g., clinics or emergency department), and ancillary services (e.g., radiology or laboratory services).[56] Ancillary services are direct costs not tied to room and board, such as operating room fees or radiology.[57] Another way to define *ancillary services* is services that hospitals provide without knowing in advance whether they will be billed as inpatient or outpatient. In an example presented by the Northern New England chapter of the Health Care Financial Management Association, 36 percent of a hospital's ancillary costs were paid by Medicare, of which almost all were attributed to outpatient services.[58]

### A Cost-Plus System

Medicare's payment updates are based on a base rate and market basket in combination with the MCRs. However, these reports simply accept systemic cost increases as a feature, not a bug. In training materials for continuing professional education, a large accounting and professional services firm teaches that "auditors typically focus on DSH [Disproportionate Share Hospital payments], bad debts, etc. & *pay little or no attention to the cost side*" of the prospective payment systems."[59] Although government auditors are incentivized to audit costs accurately, they do not question whether costs are too high. Medicare pays for capital-related costs via the Capital Prospective Payment System. One early observer of the system

54 CMS, "Cost Reports," updated January 13, 2026, https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports.

55 Faith Asper, "Introduction to Medicare Cost Reports," Research Data Assistance Center, University of Minnesota, 2025, 5, https://resdac.org/sites/datadocumentation.resdac.org/files/Introduction%20to%20Medicare%20Cost%20Reports%20%28Slides%29_0.pdf.

56 Deb Dorain and Anne Fecto, "The ABC's of Medicare Cost Reports," Healthcare Financial Management Association, May 4, 2023, https://www.hfma.org/wp-content/uploads/2023/05/crseries2theabcsofcostreporting-nne.pdf.

57 CMS, *National Health Expenditure Accounts: Methodology Paper, 2024*, updated January 2026, 9, https://www.cms.gov/files/document/definitions-sources-and-methods.pdf.

58 Dorain and Fecto, "The ABC's of Medicare Cost Reports," 37.

59 David Hall et al., "Hospital Cost Report Training," Forvis CPE Training, October 17, 2023, https://www.forvismazars.us/getattachment/8f5e22ab-8751-4654-830f-fe4999009468/Hospital-Cost-Report.pdf (emphasis added).

noted: "Certainly, in the private sector, it is almost impossible to think of a good or service for which the unit of payment separately identifies capital from the other inputs used in producing the good or service."[60] Because Medicare pays explicitly to reimburse capital expenditure, hospitals have little incentive to make capital investments efficient.

Last year, the Trump administration made a significant first step to improving MCRs by requiring hospitals to include median MA rates in their reports. There is a generally close correlation between relative payments across diagnosis-related groups in Medicare and commercial plans. Nevertheless, at the margin, there are some services where commercial weights for certain services or bundles are different than Medicare rates, and this represents useful information for Medicare rates better reflecting market conditions and value.[61] The change also creates an opportunity for an eventual divergence such that Medicare is no longer the main driver of inpatient hospital payment rates, particularly as MA penetration increases.

### "Relative Efficiency"

The Medicare Payment Advisory Commission (MedPAC) is a congressional agency that provides policy advice to Congress on Medicare payment and health care delivery issues. MedPAC categorizes 13 percent of hospitals as "relatively efficient." In 2024, these hospitals had a Medicare margin of –1 percent, versus –10 percent overall.[62]

Here, we find a circularity problem: Current levels of efficiency influence the measurement of that efficiency. For example, the group of hospitals that MedPAC labeled "relatively efficient" had standardized costs per unit that were no more than 93 percent of the national median, mortality no more than 89 percent of the national median, and readmissions no more than 93 percent of the national median.[63]

However, being below the median in these metrics does not mean a hospital is efficient — it may only mean it is relatively less *inefficient* than others. If most hospitals are deeply inefficient (in whatever metric used), then a top-performing hospital may simply be less inefficient rather than actually providing a model for high efficiency.

60 Philip G. Cotterill, "Prospective Payment for Medicare Hospital Capital: Implications of the Research," *Health Care Financing Review* 1991 Annual Supplement (March 1992): 79.

61 Brian Blase and Jackson Hammond, "Paragon Submits Public Comment on the 2026 Physician Fee Schedule Proposed Rule," Paragon Health Institute, September 13, 2025, https://paragoninstitute.org/medicare/paragon-submits-public-comment-on-the-2026-physician-fee-schedule-proposed-rule/.

62 MedPAC, *Medicare Payment Policy*, March 2026, 81.

63 MedPAC, *Medicare Payment Policy*, March 2026, 81.

When taxpayer dollars continue to flow regardless of hospital efficiency and when more dollars flow if inefficiency increases, there is little incentive — especially in comparison to private market actors — for a hospital to try to break free of the pack and improve efficiency.

### Inconsistent Financial Reporting

The Healthcare Financial Management Association, a professional society composed of finance professionals associated with hospitals, recently published a caution:

> Financial statements, tax/information returns and Medicare cost reports are key information sources for the healthcare industry, but many times they convey seemingly contradictory information, which creates confusion for both management and external stakeholders.[64]

## Overall, Hospitals Are Not Unprofitable and Have Low Financial Risk

### Types of Cost

Hospital advocates and associations typically argue that hospitals lose money on Medicare and Medicaid. However, this claim flows from the way they choose to measure margin. A more appropriate metric indicates that Medicare patients are, in fact, often profitable, and Medicaid patients are also likely a source of positive net revenue, *not a net loss*.

Getting to the truth of profit margins comes down to how hospitals allocate costs. Like other businesses, hospital costs are typically sorted into two sets: (1) fixed or variable and (2) direct or indirect. These sets overlap — a cost could be both fixed and indirect or variable and direct.

A fixed cost remains constant regardless of how many services the hospital provides. A variable cost changes in proportion to how many services are provided. For example, a new MRI machine is classified as a fixed cost, whereas drugs administered to patients constitute variable costs. MedPAC estimates that "roughly" 80 percent of hospital costs are variable, implying that 20 percent of costs are fixed.[65]

Direct costs are those that can be more easily tracked to specific services, whereas indirect costs cannot. For example, a nurse fully employed in an emergency department is treated as a direct cost for that department, whereas an administrator over the entire hospital is not. Demonstrating how difficult it can be to categorize direct versus indirect costs, a literature

64 Healthcare Financial Management Association, "Assessing Reality in Health Care Financial Information," 2023, 3, https://www.hfma.org/wp-content/uploads/2023/04/HFP_230316_PP-Whitepaper.pdf.

65 MedPAC, *Medicare Payment Policy: Report to Congress*, March 15, 2021, 62, https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/.

review concluded that *between 30 percent and 85 percent of costs* can be considered unrelated to patient care (that is, "indirect"), depending on the measurement used.[66]

Some studies rely on the Healthcare Cost Report Information System (a database curated by CMS) to examine costs systemically. However, each study and even each hospital categorizes spending differently, making comparisons challenging. Most recently, a study by Trilliant Health estimated spending on items other than direct patient care amounted to two-thirds of hospitals' expenses in 2023.[67] This study included management and administration, overhead, home office and affiliates, capital-related, and other operating non-labor-related costs. A previous study — which defined *overhead* alone as non-patient-related costs such as employee benefits, administrative staff, and capital costs — estimated overhead at 46 percent of total costs in 2010, a proportion unchanged since 1996.[68]

Using the same dataset, a more recent study covering 2011-2022 looked at the narrower category of administrative and general costs. Unlike overhead, which includes costs allocated to specific departments, these costs exclude costs not attributable to specific departments. The study found that administrative and general expenses amounted to 20 percent of all expenses in urban hospitals and 17 percent in rural hospitals in 2022. Little changed over the years.[69] Although they do not use standard definitions of costs not associated with direct patient care, these studies agree those costs have increased at about the same rate as costs for patient care, indicating no productivity growth.

The IRS regulates executive compensation in tax-exempt entities through its private inurement doctrine and related rules, which are designed to ensure that tax-exempt entities' resources are not spent to benefit insiders.[70] Nevertheless, median executive compensation rose by 23.4 percent from 2018 to 2022 at 20 tax-exempt hospitals randomly selected from across the United States. The increase was not uniform. For example, compensation in the Mayo Clinic's executive suite increased from $148 million to $159 million (just under 8 percent), while compensation at the Cleveland Clinic increased by 25 percent from $91 million to $116 million. On the other hand, executive compensation at the much smaller New England Baptist Hospital in Boston almost tripled from $6 million to $18 million.[71]

66 Rebecca R. Roberts et al., "Distribution of Variable vs. Fixed Costs of Hospital Care," *JAMA* 281, no. 7 (1999): 644–649, cited in Kalman et al., "Hospital Overhead Costs."

67 Patton and Oakes, "Hospital Administrative Expenditures."

68 Kalman et al., "Hospital Overhead Costs."

69 Handlon et al., "Trends in Hospital Administrative Costs."

70 IRS, "Inurement/Private Benefit: Charitable Organizations," October 14, 2016, https://www.irs.gov/charities-non-profits/charitable-organizations/inurement-private-benefit-charitable-organizations.

71 Landon Saipale et al., "Dollars and Disparities: Unraveling Executive Compensation Patterns in American Non-Profit Healthcare," Cureus 16, no. 10 (2024): e70911, https://doi.org/10.7759/cureus.70911.

Mean CEO compensation at 1,113 tax-exempt hospitals rose from $996,000 to $1.3 million from 2012 through 2019 (with the 2012 amount in 2019 dollars), an increase of more than 30 percent, while registered nurse wages increased only 2.3 percent. Of this growth, 44.5 percent came from across-the-board base pay increases, 28.5 percent from more generous rewards for managing larger systems, and 27.0 percent from hospitals actually becoming larger or more profitable.[72] Remarkably, hospital quality improvements *declined* as a factor determining CEO pay during the period.[73]

The problem is not the high pay itself but *why* the pay is high: CEO compensation at tax-exempt hospitals is mostly driven by the organizations' size, profits, revenues, and growth, not any metric of quality or community benefit.[74] Although these outcomes are appropriate for investor-owned corporations, they are not appropriate for tax-exempt hospitals that are supposed to be organized for community benefit.

Hospitals' increases in overhead costs — brought on in part by the need to deal with ever-increasing complexity and larger consolidated enterprises as a share of total costs — will be an important topic in the discussion below of how Medicare payments also subsidize inefficiency.

## Charity Care, Bad Debt, Uncompensated Care, and Unreimbursed Care Are Small — While Debt Collections Rise

Another challenge to delving into hospital finances is the categorization of charity care and bad debt. Charity care is care for which hospitals do not expect reimbursement. Bad debt is made up of out-of-pocket patient expenses (co-payments and deductibles) that are not paid. Hospitals report these purported costs separately on their MCRs. Charity care is used to preserve a hospital's tax-exempt status, while bad debt is care that a hospital expected to be compensated for and thus does not count as charity care. CMS sums the components of charity care and bad debt into two categories: (1) uncompensated care, which includes charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt; and (2) unreimbursed care, which includes unpaid services to self-pay or charity or Medicaid patients (the difference between the amount Medicaid paid and the cost to treat Medicaid patients). In 2023, charity care comprised almost $31 billion and bad debt $51 billion. Uncompensated care amounted to $43 billion and unreimbursed care almost $37 billion.[75]

72 Derek Jenkins et al., "The Determinants of Nonprofit Hospital CEO Compensation," *PLOS ONE* 19, no. 7 (2024): e0306571, https://doi.org/10.1371/journal.pone.0306571.

73 Derek Jenkins et al., "Nonprofit Hospital CEO Compensation: Does Quality Matter?," *Medical Care* 63, no. 10 (2025): 787–793, https://doi.org/10.1097/MLR.0000000000002198.

74 Jenkins et al., "The Determinants of Nonprofit Hospital CEO Compensation."

75 CMS, "Hospital Provider Cost Report, 2023," January 8, 2026, https://data.cms.gov/provider-compliance/cost-reports/hospital-provider-cost-report.

However, these are not total losses: Hospitals have flexibility in reporting these data and have an obvious incentive to report the highest costs possible. Also, Medicare reimburses hospitals for some uncompensated care. Further, tax-paying hospitals, which have no obligation to provide charity care, allocate a similar or greater share of operating expenses to charity care as tax-exempt hospitals do.[76] As a share of total hospital operating costs, charity care represents only a small fraction — raising questions about whether the value of hospitals' tax exemptions and subsidies is commensurate with the level of uncompensated care they provide.

## Tax-Exempt Hospitals Have Artificially Low Financing Costs

Nearly three-quarters of privately operated community hospitals (71 percent) benefit from tax-exempt status.[77] Although they do not provide more charity care than tax-paying hospitals do, their status allows them to escape corporate income tax as well as some state and local taxes, including property taxes.[78] A recent estimate indicated that this will reduce federal tax revenue by roughly $260 billion over 10 years, starting in 2024.[79] Exemption from state and local taxes more than doubles the break, amounting to $37.4 billion in 2021 alone.[80]

Further, interest payments from tax-exempt hospitals are free of income tax to investors. This allows them to issue debt at significantly lower rates than taxable corporations can. At the beginning of February 2026, tax-exempt borrowers could issue debt at an interest rate 1.66 percentage points lower than the rate for taxable borrowers.[81]

## The Challenges of Measuring Hospital Profitability

Hospitals are similar to hotels or airlines in the following sense: profitability depends on what is being measured. Prices for hotel rooms or flights are highly variable because the marginal cost of putting a guest in a room or a passenger in a seat is low relative to the total cost of operating the hotel or airline. However, in the long run, the hotel or airline must cover its fixed costs, too. Because price-sensitive consumers rent hotel rooms and buy airline tickets, hotels and airlines have incentives to develop business plans that reduce fixed costs over time. Unlike hotels or airlines, however, hospitals face little competitive pressure to reduce fixed

76 Ge Bai et al., "Analysis Suggests Government and Nonprofit Hospitals' Charity Care Is Not Aligned with Their Favorable Tax Treatment," *Health Affairs* 40, no. 4 (2021): 629–636, https://doi.org/10.1377/hlthaff.2020.01627; Joseph D. Bruch and David Bellamy, "Charity Care: Do Nonprofit Hospitals Give More Than For-Profit Hospitals?," *Journal of General Internal Medicine* 36, no. 10 (2021): 3279–3280, https://doi.org/10.1007/s11606-020-06147-9.

77 AHA, "Fast Facts on U.S. Hospitals, 2026," February 3, 2026, https://www.aha.org/statistics/fast-facts-us-hospitals.

78 AHA, "Fact Sheet: Nonprofit Hospitals' Tax-Exempt Status," September 2025, https://www.aha.org/fact-sheets/2025-01-24-fact-sheet-nonprofit-hospitals-tax-exempt-status.

79 Committee for a Responsible Federal Budget, "The Federal Tax Benefits for Nonprofit Hospitals," June 12, 2024, https://www.crfb.org/papers/federal-tax-benefits-nonprofit-hospitals.

80 Elizabeth Plummer et al., "Estimation of Tax Benefit of US Nonprofit Hospitals," *JAMA* 332, no. 20 (2024): 1732–1740, https://doi.org/10.1001/jama.2024.13413.

81 *Wall Street Journal*, "Bond Benchmarks," February 9, 2026, https://www.wsj.com/market-data/bonds/benchmarks.

costs over time because administered prices, favorable political treatment, and subsidies and other government advantages adjust upward as reported costs rise, insulating hospitals from the productivity discipline that governs other capital-intensive industries.

MedPAC examines two measures of profitability that include revenues from all payers: *total margin* and *operating margin*, as well as measures specific to Medicare (See Table 2).

*Total margin* is the percentage of revenue from all income streams remaining as profit after accounting for all costs. Total margin captures a hospital's complete financial performance — including investment returns, philanthropic support, and other income streams derived from sources other than patient care.

In contrast, by excluding the impact of investments and donations, *operating margin* isolates how well the hospital performs its primary mission of delivering health care services.[82] However, when hospitals calculate operating margin, they are dividing total operating revenue by total operating expenses — which include both variable *and* fixed costs. In other words, operating margin does not indicate whether a hospital makes money on each individual patient, because it includes fixed costs that do not change based on patient volume.

Historically, the most profitable patients for hospitals have employer-based coverage. This is then followed by patients with non-ACA individual plans, then those with ACA plans, followed by patients with Medicare and Medicaid.[83] However, Medicaid patients are now the second most profitable patients for hospitals in many states as total Medicaid payments have risen near average commercial rates in many states through the growth of SDPs.[84]

When all the different payers and sources are totaled, hospitals' all-payer *total margin* increased from 2.3 percent in 2022 to 6.5 percent in 2024.[85] However, this change included an increase in income from financial investments, which soared from $7 billion in losses in 2022 to $18 billion in gains in 2024.[86]

In 2024, for every dollar hospitals earned from providing services, they kept about 7 cents after covering all costs. That is called the all-payer operating margin, which was 6.5 percent in

82 MedPAC, *Medicare Payment Policy*, March 2026, 52, 55.

83 Caroline Hanson et al., "Providers Paid Substantially Less by Marketplace Nongroup Insurers Than by Employer Small-Group Plans, 2021," *Health Affairs* 43, no. 12 (2024): 1672–1679, https://doi.org/10.1377/hlthaff.2024.00913; MACPAC, "Medicaid Hospital Payment."

84 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

85 MedPAC, *Medicare Payment Policy*, March 2026, 76.

86 MedPAC, *Medicare Payment Policy: Report to Congress*, March 2025, 78, https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy*, March 2026, 77.

2024, up from 5.1 percent in 2023.[87] In 2023, one-quarter of hospitals had an operating margin of more than 10 percent, and one-quarter had a margin of less than negative 4 percent.[88]

However, a hospital's operating margin does not really show the full picture. Hospitals have many fixed costs that stay relatively constant, such as electricity bills, routine maintenance, and paying office staff. When a hospital takes care of a patient, it also has variable costs, including medicine, bandages, and patient meals, which change depending on how many patients are treated.

Here is an example: A hospital gets $1,000 for taking care of a patient. It spends $600 on things just for that patient (medicine, supplies, and food). That leaves $400 to help pay for large fixed costs such as the building or salaries. Even if the hospital as a whole is losing money, taking care of more patients can still help — because every extra patient brings in more net revenue to cover those large, fixed costs.

## Profit Margins from Medicare

The Medicare payment system ensures that a hospital does not have to reduce fixed costs over the long term to stay profitable. Instead, Medicare payments change according to a market basket that accepts, rather than negotiates, costs. This flaw is a major reason why efficiency gains are so elusive in the hospital sector. It is compounded by how CMS uses the MCRs (discussed at greater length below) to largely take at face value what individual hospitals attribute to their Medicare patients for medical and nursing education and uncompensated care and what hospitals collectively attribute to local labor costs, capital costs, and particularly expensive outlier patients.

The AHA claims that hospitals lose money on Medicare patients, but this is because it neglects to differentiate between different measures of profitability, choosing to highlight one measure that many hospitals may lose money on.[89]

In an effort to penetrate some of these complexities, MedPAC defined a new term in 2015: *marginal profit*.[90] The marginal profit provides information about whether providers have a financial incentive to see Medicare patients. In considering whether to treat a patient, the

87 MedPAC, *Medicare Payment Policy*, March 2026, 63.

88 MedPAC, *Medicare Payment Policy*, March 2025, 77.

89 AHA, "Costs of Caring," March 2026, https://www.aha.org/costsofcaring.

90 MedPAC, "MedPAC Presents New Marginal Cost Analysis," December 21, 2015, https://www.medpac.gov/medpac-presents-new-marginal-cost-analysis/.

## Table 2: MedPAC Margin Descriptions

| Profitability Measure | Description | Example |
|---|---|---|
| FFS Medicare margin | The percentage of revenue from fee-for-service (FFS) Medicare that is left as profit after accounting for the allowable costs of providing services to FFS Medicare patients. | A hospital receives $10 million from FFS Medicare and spends $9.5 million delivering those services. Its FFS Medicare margin is 5 percent. |
| FFS Medicare marginal profit | The percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., building costs). If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a financial disincentive to care for an additional FFS beneficiary. | A hospital gets an extra $20,000 in Medicare revenue from treating additional FFS Medicare patients, and the added staffing, supplies, and other variable costs are $14,000. The marginal profit is 30 percent. |
| All-payer total margin | The percentage of revenue from all payers and sources that is left as profit after accounting for all costs. | A hospital has $100 million in total revenue from Medicare, Medicaid, private insurance, and other sources, and $110 million in total costs. Its all-payer total margin is -10 percent. |
| All-payer operating margin | The percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. | A hospital earns $100 million from patient care and other operating revenue, with $95 million in total costs. Excluding donations and investment gains, its all-payer operating margin is 5 percent. |

SOURCE: Medicare Payment Advisory Committee (MedPAC), 2026, "March 2026 Report to the Congress: Medicare Payment Policy."

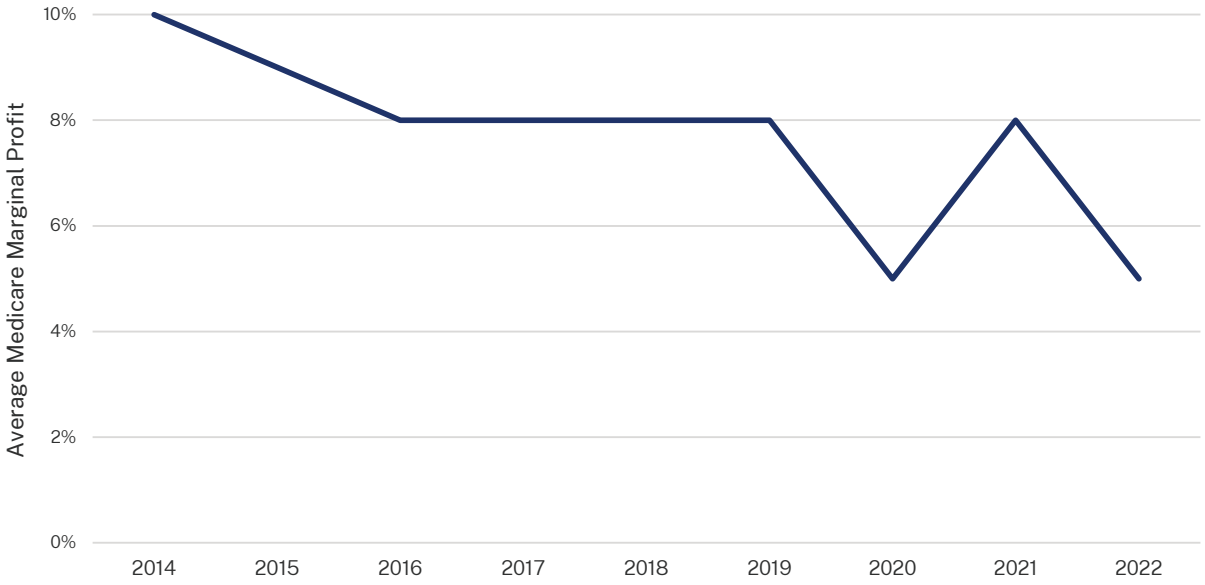
provider compares the marginal revenue it will receive (i.e., the Medicare payment) with the marginal cost.

Hospitals' Medicare marginal profit is consistently positive, as shown in Figure 2. The Medicare marginal profit exceeded 10 percent in 2014 and was about 9 percent in 2015.[91] From 2016 through 2019, hospitals' Medicare marginal profit was 8 percent.[92] In 2020, Medicare marginal profit dropped to 5 percent, returned to 8 percent in 2021, dropped to 5

91 MedPAC, *Medicare Payment Policy: Report to Congress*, March 2016, 75, https://www.medpac.gov/document/march-2016-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy: Report to Congress*, March 2017, 64, https://www.medpac.gov/document/mar-2017-report/.

92 MedPAC, *Medicare Payment Policy: Report to Congress*, March 2018, 66, https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_entirereport_sec_rev_0518-pdf/; MedPAC, *Medicare Payment Policy: Report to Congress*, March 2019, 78, https://www.medpac.gov/document/march-2019-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy: Report to Congress*, March 2020, 70, https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/; MedPAC, *Medicare Payment Policy*, March 2021, 65.

## Figure 2: On Average, Hospitals Earn Marginal Profits From Treating Medicare Enrollees




SOURCE: MedPAC annual reports to Congress on Medicare Payment Policy, 2017-2023.
NOTE: Marginal profit = [payments for Medicare services - (total Medicare costs - fixed building and equipment costs)] / Medicare payments

percent again in 2022, and remained positive in 2023 (the most recent year for which it is reported).[93]

This explains why hospitals continue to accept Medicare patients, even though the more commonly discussed *operating margin* is consistently negative. In other words, hospitals' fixed costs do not appreciably change by accepting additional Medicare patients, so they make money from doing so because the payment covers their variable costs associated with treating new Medicare patients.

MedPAC's estimates for 2022 broke down Medicare marginal profit by type of hospital. Tax-paying hospitals had a marginal profit of 16 percent versus 3 percent for tax-exempt hospitals. Rural hospitals in counties without any towns with at least 10,000 residents earn additional payments from Medicare (described below) and had a marginal profit of 11 percent versus 5 percent for urban hospitals.[94]

93 MedPAC, *Medicare Payment Policy: Report to Congress*, March 2022, 68, https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy: Report to Congress*, March 2023, 93, https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy: Report to Congress*, March 2024, 60, https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/; MedPAC, *Medicare Payment Policy*, March 2025, 68.

94 MedPAC, *Medicare Payment Policy*, March 2024, 60.

When the AHA asserts that hospitals lose money on Medicare beneficiaries, in most cases this refers to the *FFS Medicare margin*. However, FFS Medicare margin includes all costs including fixed building and equipment costs. These costs do not vary when a hospital treats one more Medicare patient. MedPAC defines *Medicare marginal profit* as the profit earned from treating a Medicare patient — that is, revenue minus variable costs.[95] Medicare marginal profit is positive.

To illustrate the difference between MedPAC's use of these two terms — *marginal profit* and *margin* — here is an illustration: Suppose a hospital earns $55 million annually from Medicare claims. Its operating costs are $65 million. So it has an operating loss of $10 million, which amounts to a negative margin of 15 percent ($10 million divided by $65 million). However, those operating costs comprise fixed costs of $13 million and variable costs of $52 million, so its marginal profit is $3 million, which results in a positive marginal profit of 5 percent ($3 million divided by $52 million). In other words, Medicare patients contributed to overall profits for the hospital. In MCRs, hospitals self-report the overhead they allocate to Medicare patients, which is an input into calculating Medicare margin.

According to MedPAC, hospitals overall have negative Medicare margins from 7.9 percent in 2019 to 12.1 percent in 2024 (excluding COVID-19 pandemic relief funds).[96] However, even more than one-quarter of hospitals made operating profits on Medicare in 2023: The 75th percentile of hospitals earned a margin of 2.3 percent or more.[97]

## Profit Margins from Medicaid

Another significant area in need of a more accurate financial measurement relates to hospital profitability from Medicaid. This is all the more critical because Medicaid payment rates augmented by the surge in SDPs are often significantly *higher* than Medicare rates. Although precise estimates of Medicaid marginal profit are unavailable, the fact that all-in Medicaid payments generally now exceed Medicare rates strongly suggests that hospitals also earn positive marginal profit on Medicaid patients. However, this may change. The reforms to Medicaid payment contained in the OBBB will improve incentives for hospitals to become more efficient.[98]

95 MedPAC, *Medicare Payment Policy*, March 2024, 155.

96 MedPAC, *Medicare Payment Policy*, March 2026, 79.

97 MedPAC, *Medicare Payment Policy*, March 2025, 81.

98 Blase, "Debunking the Myths."

## Investment Income Is Volatile but Significant

An underappreciated and underdiscussed aspect of hospital profitability is hospital income from financial investments. This investment income weakens claims that hospitals operate on razor-thin margins and raises questions about whether public subsidies intended to support patient care are instead financing large investment portfolios. For instance:

- An analysis of 2,590 hospitals' financial reports for 2017 indicated high hospital profits. However, there was significant variance in investment performance among hospitals: The top quartile earned almost all the investment income, and their overall net income would have dropped by 31 percent without investment income.[99]
- A separate study of 10 large tax-exempt hospitals revealed that revenue from patient care increased by under 1 percent between 2021 and 2022, but profit from financial investments turned into a loss, so the ratio of investment return to total revenue decreased by 185 percent over the same period.[100]
- In 2024, hospitals earned more than $18 billion in investment income, a 40 percent increase from 2023. In 2024, charitable donations to hospitals were $2 billion, an increase of 2 percent from 2023.[101]
- From 2017 through 2019, 70 percent of the average hospital's assets consisted of property, plant, and equipment and investments. These investments usually returned at least 18 percent before the COVID-19 pandemic. These high returns were true even for hospitals with "negative operating performance" during the pandemic. One accountant with an expertise in hospital financial statements wryly asked "whether there is any other strategic area within the organization responsible for such a large portion of cash flow."[102]

Given that investing performance is a central part of hospitals' financial well-being, it is important to look at more than just operating revenue when evaluating hospital finances. Although hospitals must maintain reserves necessary to remain solvent, policymakers should consider whether taxpayers are well served by allowing hospitals to act, in part, as hedge

99 Ge Bai et al., "Investment Income of US Nonprofit Hospitals in 2017," *Journal of General Internal Medicine* 35, no. 9 (2020): 2818–2820, https://doi.org/10.1007/s11606-020-05929-5.

100 Christopher M. Whaley, et al., "What's Behind Losses At Large Nonprofit Health Systems?," *Health Affairs Forefront*, March 24, 2023, https://www.healthaffairs.org/do/10.1377/forefront.20230322.44474/full/.

101 MedPAC, *Medicare Payment Policy*, March 2026, 77.

102 Robert Turner and Marek Kowalewski, "How to Keep Your Balance Sheet Steady in Tumultuous Times," Healthcare Financial Management Association, updated April 1, 2024, https://www.hfma.org/finance-and-business-strategy/how-to-keep-your-balance-sheet-steady-in-tumultuous-times/.

funds. Alternatively, they could reduce the volatility of their margins by investing their surplus cash in low-risk, stable-return assets that keep enough cash on hand to pay accounts payable and maintain stable credit ratings.

# PART 3: SHIFT FROM INPATIENT TO OUTPATIENT CARE

There is a paradox in the hospital sector: Why do prices and expenditures keep rising even as technological innovation allows more patients to receive care in outpatient, rather than inpatient, settings? The answer is critical to understanding today's dysfunction. This reality also provides insights into the anti-competitive orientation of major hospital systems.

### A Significant Change in Site of Care

One of the major changes in U.S. health care over the past three decades has been technological advances that have enabled a transition from inpatient hospital stays to outpatient care. But this has not lowered overall spending. Instead, hospitals exploited this shift — leveraging payment rules and market power to beef up profits by imposing higher costs on patients and taxpayers.

Hospital costs are significantly lower in an outpatient setting as inpatient care is usually more time-, labor-, and equipment-intensive.[103] The shift to outpatient care has helped patients, as they often prefer to heal at home when their procedures are completed, and many patients acquire infections or other adverse outcomes when in hospitals.

One measure of the impact of the transition to outpatient care has been a decline in hospital beds per capita. Hospital admissions (for at least one overnight stay) per 1,000 people dropped from 120 in 2000 to 99 in 2024, a 17.5 percent decline.[104] Meanwhile, hospital outpatient visits have trended upward from 1,848 per 1,000 people in 2000 to 2,499 in 2024 — a 35.2 percent increase.[105]

Ambulatory surgery centers (ASCs) have grown to fill the gap. According to MedPAC, ASCs typically offer more convenient locations, shorter wait times, lower patient payments, and easier scheduling than hospital outpatient departments do. They also offer physicians more control over their work environment. ASCs receive lower payments from Medicare than

103 Ge Bai and Hossein Zare, "Hospital Cost Structure and the Implications on Cost Management During COVID-19," *Journal of General Internal Medicine* 35, no. 9 (2020): 2807–2809, https://doi.org/10.1007/s11606-020-05996-8.

104 KFF, "Hospital Admissions per 1,000 Population by Ownership Type," https://www.kff.org/state-health-policy-data/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

105 KFF, "Hospital Outpatient Visits per 1,000 Population by Ownership Type," https://www.kff.org/state-health-policy-data/state-indicator/outpatient-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

hospitals do.[106] Physicians can own ASCs, whereas after the Affordable Care Act, physicians were severely limited in taking ownership of hospitals. The volume of ASC surgical procedures per Medicare FFS beneficiary rose by 3.5 percent in 2024, up from an annual average rate of 1.3 percent from 2019 to 2023.[107] Nevertheless, the government is still protecting hospitals from competition from ASCs, especially because Medicare's payment policies incentivize physicians to sell their practices to hospitals.

Hospital systems have responded vigorously to government payment policies that pay more for identical services in hospitals than in other settings by aggressively acquiring physician practices. In 2012, 25.8 percent of physicians were employed by hospitals. By the beginning of 2024, that proportion increased to 55.1 percent.[108] This shift was especially noticeable with primary care doctors: 28 percent were affiliated with hospitals in 2009 versus 48 percent in 2022.[109]

Primary care practices are especially attractive to hospital systems because they refer patients to them for additional services, and government programs pay a much higher amount for services in outpatient facilities owned by hospitals than in offices owned by independent physicians.

Figure 3 shows cumulative base-rate changes since 2016 for the three different Medicare payment systems: inpatient care (the Inpatient Prospective Payment System, or IPPS), outpatient care (the Outpatient Prospective Payment System, or OPPS), and clinicians (PFS). The clinician rates dropped 7 percent from 2016 through 2026, while outpatient and inpatient rates increased 26 percent and 30 percent, respectively.[110] The estimated 3.4 percent increase in the PFS for 2026 represents a one-time payment increase enacted in the OBBB.[111]

### FFS Medicare: Shifting from Inpatient to Outpatient Revenue

In 2007, FFS Medicare's inpatient spending for hospitals amounted to $101 billion. Inpatient spending in nominal terms stayed relatively flat through 2023, meaning a large decline in real terms. In 2023, FFS Medicare inpatient spending was $103 billion. In contrast, Medicare's outpatient spending to hospitals increased from $25 billion to $66 billion, as shown in Figure 4.

106 MedPAC, *Medicare Payment Policy*, March 2026, 325.

107 MedPAC, *Medicare Payment Policy*, March 2026, 325.

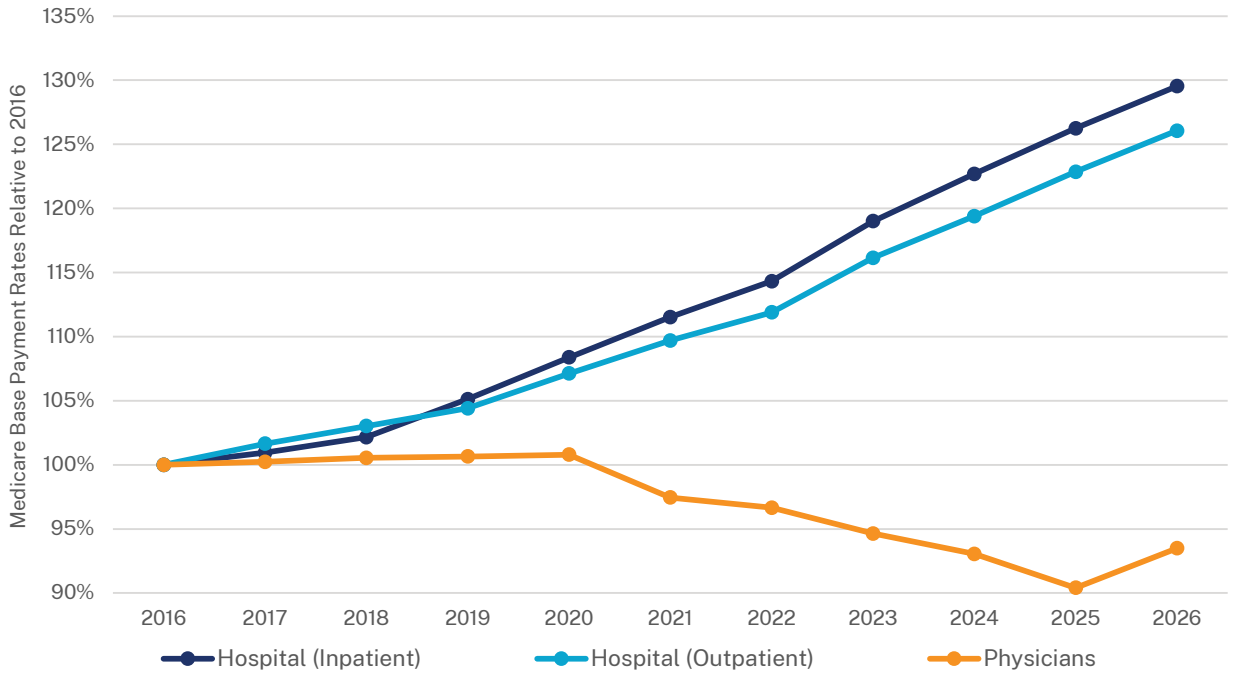
108 Avalere Health, "Updated Report," 5, 14.

109 Yashaswini Singh et al., "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications," *JAMA Health Forum* 6, no. 1 (2025): e244935, https://doi.org/10.1001/jamahealthforum.2024.4935.

110 Jackson Hammond and Mark Howell, "Medicare Base Payment Rates for Hospitals Have Increased While Physician Base Payment Rates Have Declined," Paragon Health Institute, March 2, 2026, https://paragoninstitute.org/paragon-pic/medicare-base-payment-rates-for-hospitals-have-increased-while-physician-base-payment-rates-have-declined/.

111 Blase and Hammond, "Paragon Submits Public Comment."

## Figure 3: Medicare Base Payment Rates for Hospitals Have Increased While Physician Base Payment Rates Have Declined




SOURCES: Paragon staff calculations based on final Medicare payment rules and enacted legislation. For 2026, CMS introduced two conversion factors on the Physican Fee Schedule, one for Qualifying Advanced Alternative Payment Model Participants and one for Nonqualifying ones. The number for 2026 "Clinicians" reflects the weighted average of the 2026 conversion factors for alternative payment model participants and non-participants, estimated by Paragon staff.

Inpatient hospital spending stayed flat while hospitals treated far fewer Medicare FFS patients in inpatient settings. Table 3 shows Medicare's discharge rate — how many people per 1,000 Medicare beneficiaries were released from hospitals each year. This number dropped by almost 35 percent, meaning far fewer people were being admitted to hospitals.

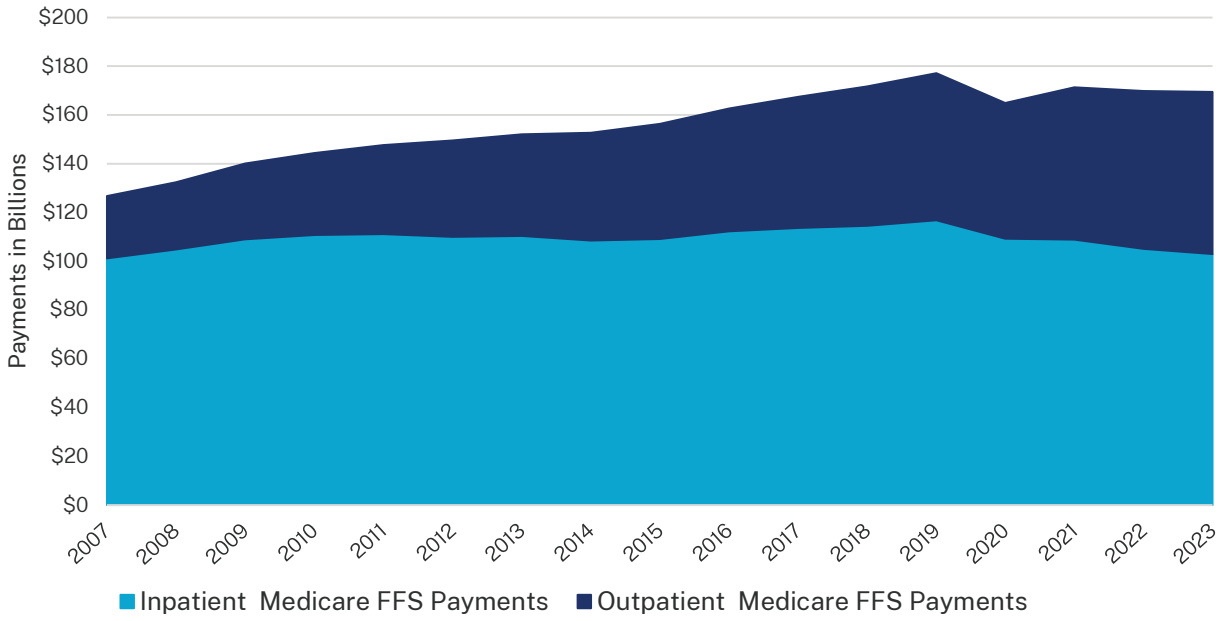
Hospital revenue from inpatient care increased, however, because they were receiving more Medicare payments per admission. The growth in total inpatient spending came from price inflation rather than increased utilization, which is a crucial distinction for understanding health care cost drivers.[112]

### How Construction Costs Further Demonstrate the Shift to Outpatient

The far-reaching consequences of the shift from inpatient to outpatient care — combined with government incentives that reward care in a hospital outpatient setting — can be seen in the most concrete terms: hospital construction. Government rules and subsidies heavily influence

112 CMS, "CMS Program Statistics — Medicare Inpatient Hospital," March 6, 2023, https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/cms-program-statistics-medicare-inpatient-hospital.

## Figure 4: Medicare Fee for Service Outpatient Spending Has Tripled Since 2007 While Inpatient Spending Remained Steady




SOURCE: CMS, "Medicare Geographic Variation - by National, State & County," 2025, https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county.

NOTES: Inpatient Medicare FFS Payments are for Hospital Inpatient services, which are comprised of Inpatient Prospective Payment System (IPPS), Critical Access Hospitals (CAH), Inpatient Psychiatric Facility (IPF) services, and other inpatient Part A services. Outpatient Medicare FFS Payments are for Hospital Outpatient department services, which are comprised of hospitals reimbursed under the Outpatient Prospective Payment System (OPPS) and Critical Access Hospital (CAH) outpatient department services.

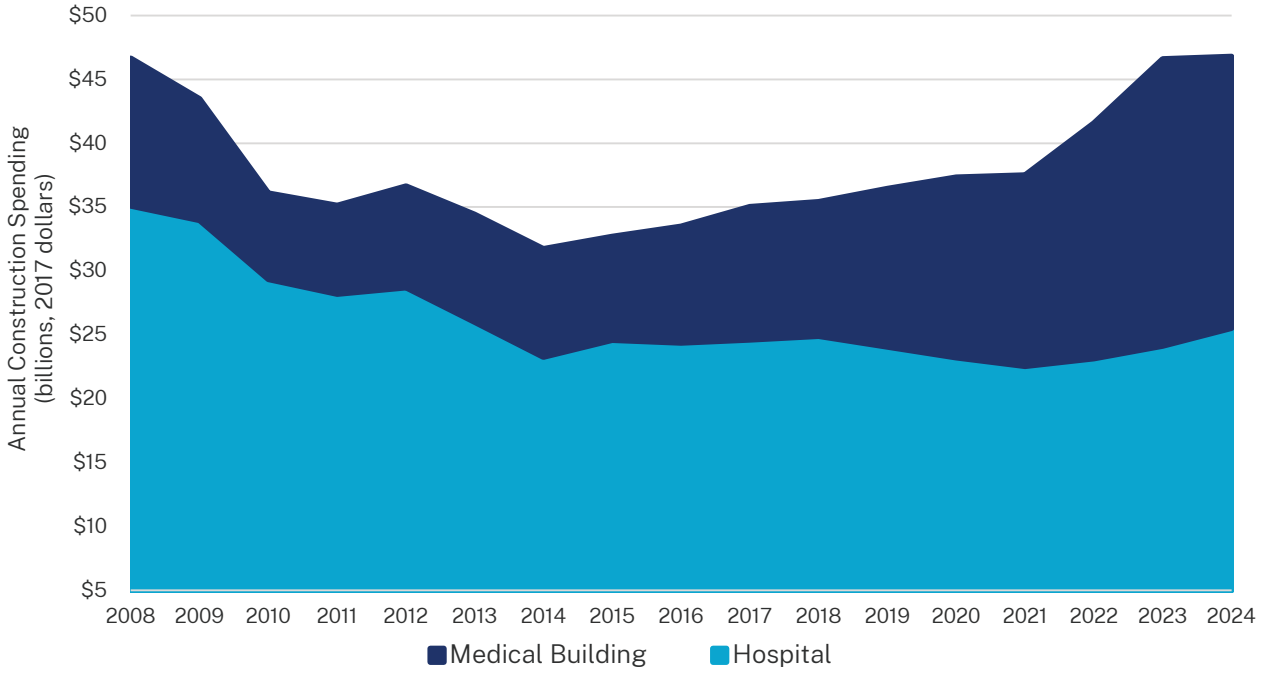
## Table 3: Fee for Service Medicare Total Discharges, 2008-2021

| Item | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | '08-'21 % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Discharges (million) | 12.7 | 12.2 | 12.2 | 12.2 | 11.9 | 11.4 | 11.1 | 11.1 | 11.1 | 11.0 | 10.8 | 10.5 | 8.8 | 8.3 | -34.6% |
| Total Beneficiaries | 35.1 | 35.1 | 35.6 | 36.2 | 36.9 | 37.3 | 37.5 | 37.7 | 38.3 | 38.3 | 38.4 | 38.3 | 37.5 | 36.1 | 2.8% |
| Discharges per 1,000 Beneficiaries | 363 | 347 | 343 | 337 | 322 | 307 | 297 | 295 | 289 | 288 | 281 | 274 | 234 | 232 | -36.1% |

SOURCE: "CMS Program Statistics - Medicare Inpatient Hospital" (Baltimore, MD: Centers for Medicare & Medicaid Services, March 6, 2023), https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/cms-program-statistics-medicare-inpatient-hospital.

hospital construction decisions. Because hospitals are staffed 24 hours, seven days a week, operating costs for hospitals are higher than for medical buildings that operate during normal business hours (such as physicians' offices or clinics). So it is not surprising that capital spending now prioritizes medical buildings.

## Figure 5: Medical Building Construction Spending Has Increased as Hospital Construction Spending has Declined




SOURCE: U.S. Census Bureau, Value of Construction Put in Place Survey (VIP), Historical Construction Spending Data. https://www.census.gov/construction/c30/data/index.html.

NOTE: Includes spending by private sector or state and local government, not federal government.

Figure 5 shows construction spending from 2008 through 2024. This figure shows both hospitals and medical buildings. As discussed below, hospitals have increased their ownership of non-hospital practices, so many medical buildings that are not hospitals are owned by hospitals and thus part of the hospital outpatient payment system.

In both 2008 and 2023-2024, construction spending by the private sector and state and local governments on hospitals and medical buildings peaked at $47 billion (in constant 2017 dollars), according to the U.S. Census Bureau's Construction Spending Survey, as shown in Figure 5.[113]

However, the composition of that $47 billion changed significantly. In 2014 — the year the key provisions of the ACA took effect — overall construction spending bottomed out at $32 billion. This was mostly due to a significant reduction in hospital construction spending. By 2015, spending had shifted sharply toward medical buildings. Hospital construction fell 27 percent

113 Census Bureau, "Value of Construction Put in Place Survey," February 3, 2025, https://www.census.gov/construction/c30/c30index.html.

from $35 billion in 2008 to $26 billion in 2024, while spending on medical building construction increased 84 percent from $12 billion to $21 billion.

Put another way, construction of medical buildings was less than one-third that of hospitals in 2008. By 2024, spending on both types of buildings was nearly equal.

## Consolidation and Reduced Competition Drives Up Prices for All Payers

By paying hospitals more than independent physicians and more than ASCs for outpatient care, Medicare payment policy — which is amplified by commercial insurers, as they often link to Medicare — has led to additional consolidation. The additional consolidation has further reduced competition and choice while increasing system-wide health care costs.

Hospital and doctors both recognize the financial upsides when hospital systems employ doctors. A 2021 study estimated that Medicare payments for physician services were $114,000 higher per physician per year if a physician was integrated into a hospital system compared to being independent of a system, with hospitals and physicians splitting the higher revenue.[114]

Government payment rules that encourage vertical consolidation do not just influence hospital decision-making. They influence doctors' decisions, too. Indeed, the decision of so many physicians to leave private practice to become hospital employees reflects their belief that they can increase what they bill and earn while minimizing their own administrative costs of practicing medicine.[115]

Hospital acquisition of physician practices is a type of vertical consolidation.[116] According to MedPAC's 2026 report, this consolidation increases hospitals' leverage over private insurers and prevents new providers from entering the market.[117]

Consolidation also increases prices for private payers, according to literature reviewed by a 2025 Government Accountability Office (GAO) report[118]:

114 Brady Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," *Health Services Research* 56, no. 1 (2021): 7–15, https://doi.org/10.1111/1475-6773.13613.

115 Carol K. Kane, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022," American Medical Association, 2023, https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.

116 Aspen Institute, "Ensuring Access, Affordability, and Quality in the Age of Healthcare Consolidation: Lessons Learned and Insights for the Future," February 7, 2025, 55, https://www.aspeninstitute.org/publications/ensuring-affordability/.

117 MedPAC, *Medicare Payment Policy*, March 2026, 15–19.

118 GAO, *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation*, September 2025, https://files.gao.gov/reports/GAO-25-107450/index.html.

- One study found a 17 percent increase in office visit prices following hospital-physician consolidation from 2010 through 2016.[119]
- A study found that hospital prices for inpatient stays increased by an estimated 3–5 percent between 2009 and 2015 as a result of hospital-physician consolidation.[120]
- Another study found that consolidation between hospital systems and obstetricians and gynecologists from 2011 through 2016 led to commercial price increases for childbirths: 15 percent for physician services and 3 percent for hospital services.[121]
- One study found that hospital-affiliated physicians in four specialties were least likely to provide selected services in lower-cost settings. Reimbursement for a stress test performed in a hospital outpatient department was about 2.5 times higher than when performed in a lower-cost setting.[122]
- Another study found that hospital ownership of physician practices was associated with higher physician prices for primary care, orthopedics, and cardiology office visits (but not for obstetrics and gynecology or oncology visits) between 2012 and 2016.[123]
- A study that examined the effects of participation by independent primary care practices in a hospital-led Medicare accountable care organizations (which is soft or pseudo-consolidation, because although there is no ownership change, the hospital and physician practice negotiate as a unit with the payer). Private prices increased 4 percent on average, with a 20 percent or greater increase for 7 percent of physician practices.[124]

Other studies not captured in the GAO report show similar results:

- In Florida, a study of physician practices acquired by hospitals from 2009 to 2015 concluded that the amounts physicians charged increased more

119 William Encinosa et al., "Does Physician-Hospital Vertical Integration Signal Care-Coordination? Evidence from Mover-Stayer Analyses of Commercially Insured Enrollees," National Bureau of Economic Research, December 2021, https://doi.org/10.3386/w29599.

120 Haizhen Lin et al., "Hospital Pricing Following Integration with Physician Practices," *Journal of Health Economics* 77 (May 2021): 102444, https://doi.org/10.1016/j.jhealeco.2021.102444.

121 Lin et al., "Hospital Pricing Following Integration with Physician Practices."

122 Deepak A. Kapoor et al., "Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures," *Journal of Market Access and Health Policy* 13, no. 3 (2025): 36, https://doi.org/10.3390/jmahp13030036.

123 James Godwin et al., "The Association Between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence," *Inquiry* 58 (2021): 1–10, https://doi.org/10.1177/0046958021991276.

124 Peter F. Lyu et al., "Soft Consolidation in Medicare ACOs: Potential for Higher Prices Without Mergers or Acquisitions," *Health Affairs* 40, no. 6 (2021): 979–988, https://doi.org/10.1377/hlthaff.2020.02449.

than 29 percent. Moreover, increases were even higher for Medicare beneficiaries.[125]

- A study of almost 200,000 primary care physicians in 2022 indicated that the increased acquisition of physician-owned practices led to an 11 percent increase in negotiated prices.[126]
- During a period of significant hospital acquisition of primary care physicians' practices (2007 to 2013), prices for acquired physicians' services increased 14.1 percent, and spending by enrollees (deductibles, copays, and coinsurance) increased 4.9 percent.[127]

One concern about vertical integration relates to the fact that primary care physicians refer patients to specialists for procedures. When both primary care physicians and specialists are "owned" by the same hospital, Medicare pays more for the same procedures simply because, as a result of the common ownership, they are more often performed at hospital outpatient departments instead of ASCs. A study of all Medicare claims from 2013 through 2019 found that a hospital taking over a primary care practice is followed by a 5.0 percentage point increase in the use of hospital outpatient departments for arthroscopy and a 6.8 percentage point increase for colonoscopy relative to ASCs. The study noted that Medicare paid $805 for a colonoscopy with biopsy at an ASC and $1,371 at a hospital outpatient department. It concluded that if all Medicare patients received care from hospital-owned primary care practices, Medicare spending on these two procedures alone would have increased by $315 million during the period and enrollees' out-of-pocket spending by $63 million.[128]

Although ASCs have been historically owned by physicians, they too feel a gravitational pull to being acquired by hospitals. In 2023, 21 percent of ASCs were co-owned by physicians and hospitals.[129] Hospitals' increasing acquisition of ASCs would further reduce competition within markets and lead to price and expenditure increases for surgeries and procedures.

One factor driving price increases is that hospitals are naturally inclined, to the extent permitted, to restrict referrals to within their systems and discourage referrals outside their systems. A referral or self-referral outside the system is identified as "leakage," which

125 Michael R. Richards et al., "Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets," RAND, July 6, 2020, 6, https://www.rand.org/pubs/working_papers/WRA621-1.html. Although "charges" may not reflect fees actually paid in commercial markets, where payers negotiate discounts, the increase indicates a shift to a higher fee schedule for Medicare patients.

126 Singh et al., "Growth of Private Equity."

127 Corey Capps et al., "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–152, https://doi.org/10.1016/j.jhealeco.2018.04.001.

128 Christopher M. Whaley and Xiaoxi Zhao, "The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics," *Journal of Public Economics* 238 (October 2024): 105175, https://doi.org/10.1016/j.jpubeco.2024.105175.

129 William Rifkin, "The Role of Ambulatory Surgical Centers," MCG Health, August 17, 2023, https://www.mcg.com/blog/ambulatory-surgical-centers/.

hospitals seek to prevent, notwithstanding whether an external specialist is better or more economical for a patient.

Because hospitals now own most physician practices, policies that seek to prevent leakage can interfere with a physician's professional judgment with respect to the best specialist for a given patient's needs. Although the federal Stark law tries to prevent hospitals from interfering in the practice of medicine, hospitals have found ways to direct referrals among their employed or contracted physicians.

Thus, federal laws are internally inconsistent. On the one hand, the federal government discourages physician-owned hospitals and gives hospitals an unfair advantage by paying them more than other providers, while on the other hand the government discourages hospitals from directing the behavior of their employed physicians.

Beyond disempowering physicians, government-driven vertical consolidation also drives prices up because hospitals can add extra facility fees to services that did not have those fees before. When the number of physician practices shrinks because they have been rolled up into hospitals, payers are unable to negotiate as effectively. A study looked at prices paid by commercial payers from 2012 to 2016 and found that a 10 percent increase in vertical integration was associated with a 1 percent price increase for primary care, a 0.6 percent increase for orthopedics, and a 0.5 percent increase for cardiology.[130]

Hospitals have also gained market power over payers through horizontal consolidation. Large hospitals buying up smaller hospitals is a trend that has persisted for decades.[131] In 2022, 68 percent of hospitals were part of larger systems — up from 53 percent in 2005.[132]

An example shows the significant change in organization and character of these hospitals. The second largest system in the country, CommonSpirit Health, spreads across 18 Western states, has over 17,000 beds, and took in $34.5 billion in operating revenue in 2023.[133] CommonSpirit Health was born in 2019, the result of a merger between Catholic Health Initiatives and Dignity Health. Before that, Catholic Health Initiatives was launched in 1996 when the Catholic Health Corporation of Omaha, Franciscan Health System, and Sisters of Charity Health System consolidated. Dignity Health launched in 1986 as Catholic Healthcare West, a combination of hospitals owned by two congregations of the Sisters of Mercy.

130 Godwin et al., "The Association Between Hospital-Physician Vertical Integration and Outpatient Physician Prices."

131 Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (2017): 1530–1538, https://doi.org/10.1377/hlthaff.2017.0556.

132 Zachary Levinson et al., "Ten Things to Know About Consolidation in Health Care Provider Markets," KFF, April 19, 2024, https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.

133 Levinson et al., "Ten Things to Know."

More than a century before that, the Sisters of Mercy opened their first hospital in San Francisco in 1854, when eight religious sisters arrived from Ireland to care for cholera patients. They had vowed "to serve people who suffer from poverty, sickness, and lack of education."[134] Sisters of Mercy themselves take vows of poverty.[135] The charitable roots of many hospital systems have faded — with executive salaries surging to new heights. CommonSpirit Health, for example, paid its CEO $35 million in 2021.[136]

There is no evidence that these mergers — indisputably driven by government policy — improve quality of care.[137] However, the evidence on prices is consistent: Mergers within a market (for example, within a Metropolitan Statistical Area) raise prices by 20–50 percent. Perhaps more surprisingly, mergers across markets (for example, combining hospitals in different Metropolitan Statistical Areas) raise prices 6–17 percent.[138] The effect across markets might explain why there are mergers on top of mergers, such as CommonSpirit Health, which covers 18 states.

## Undermining Accountable Care Organizations

Hospitals shifting resources from inpatient to their own high-cost outpatient settings also undercuts physician-led accountable care organizations (ACOs). ACOs are groups of providers who work together to coordinate care for patients, especially those with complex conditions. Payers reward them financially if they achieve their goals.

Although ACOs have not been as transformative as initially hoped, a 2024 Congressional Budget Office (CBO) report concluded that ACOs led by independent physician groups are more successful at controlling costs than hospital-led ACOs are.[139] The CBO's review of the literature indicated two reasons for this relative success: First, independent physicians naturally want to keep their patients out of the hospital. Yet a hospital-led ACO faces an internal conflict of interest in this regard.

Second, according to CBO's review of the literature, hospitals are less able to directly control services physicians provide as compared to physician groups that manage themselves.[140] As

134 Dignity Health, "History, Mission, Vision and Values," November 4, 2024, https://www.dignityhealth.org/about-us/our-organization/mission-vision-and-values.

135 Congregation of the Sisters of Mercy, "The Vows," November 10, 2016, https://sistersofmercy.ie/the-vows/.

136 Tara Bannow, "Not-for-Profit CommonSpirit Health Paid Its CEO $35 Million in 2021," *STAT*, August 14, 2023, https://www.statnews.com/2023/08/14/not-for-profit-commonspirit-health-paid-its-ceo-35-million-in-2021/.

137 Marco Mariani et al., "Impact of Hospital Mergers: A Systematic Review Focusing on Healthcare Quality Measures," *European Journal of Public Health* 32, no. 2 (2022): 191–199, https://doi.org/10.1093/eurpub/ckac002.

138 Zach Cooper and Marty Gaynor, "Addressing Hospital Concentration and Rising Consolidation in the United States-1% Steps for Health Care Reform," Yale University, https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/.

139 CBO, *Medicare Accountable Care Organizations: Past Performance and Future Directions*, https://www.cbo.gov/publication/60213.

140 CBO, *Medicare Accountable Care Organizations*.

far back as 2014, the AHA itself published an article titled, "What Physician-Led ACOs Can Teach Hospitals."[141] A 2020 article reported that only about 20 percent of ACOs were physician-led in 2010, rising to 45 percent by 2018.[142] By driving physicians to become hospital employees, Medicare's payment policies undermine the development of these physician-led ACOs.

# PART 4: MAJOR GOVERNMENT PROGRAMS THAT BENEFIT HOSPITALS

In 2024, Medicare and Medicaid accounted for 46 percent of hospitals' $1.6 trillion in revenue.[143] However, hospitals earn significantly more than indicated by ordinary Medicare and Medicaid claims. Beyond Medicare, Medicaid, and private insurance, about one-quarter of a trillion dollars (17 percent of revenue) comes from other payment streams.[144] Some of those are less-well-known federal subsidies. This funding, these subsidies, and the rules attached to them limit competition and distort the health care sector, including by advantaging hospitals. The result: higher hospital revenues and profits and increased inefficiency.

Hospitals directly and indirectly benefit from a host of federal programs and policies, of which the major ones are listed below.[145] They can be categorized as government programs that pay directly for services, private consumption supported by government policies, and indirect subsidies that are not directly related to claims.

## Government Programs That Pay Directly for Services

### Medicare: Inpatient and Outpatient Services

***Description.*** Medicare pays hospitals for inpatient services through the IPPS and for outpatient services through the OPPS. As discussed above, these payment systems include payment distortions that benefit hospitals. A large share of Medicare beneficiaries are also enrolled in MA, where plans tend to reimburse hospitals at rates similar to traditional Medicare.

141 Marty Stempniak, "What Physician-Led ACOs Can Teach Hospitals," American Hospital Association, November 11, 2014, https://www.aha.org/hhnmag/3887-what-physician-led-acos-can-teach-hospitals.

142 David Muhlestein and Tianna Tu, "Accountable Care Organizations Are Increasingly Led by Physician Groups Rather Than Hospital Systems," *American Journal of Managed Care* 26, no. 5 (May 2020): 225–228.

143 CMS, "NHE Fact Sheet," Table 7.

144 CMS, "NHE Fact Sheet," Table 7.

145 Programs not covered in this section are Medicare New Technology Add-On Payments, Medicare Buffer Stock of Essential Medicines, Medicaid Delivery System Reform Incentive Payments, Medicare Improper Payments, Medicaid Improper Payments, CHIP Overpayments, Obamacare Overpayments, Tax Expenditure for Investors, Low-Volume Hospitals, Medicare-Dependent Hospitals, Rural Referral Centers, and Sole Community Hospitals.

***Benefit to hospitals.*** Medicare payments to hospitals totaled **$440 billion in 2024**, making this the single largest federal revenue stream to hospitals.[146] (This figure includes the indirect subsidies described below.) As explained above and below, hospitals can profit from Medicare. Commercial payers typically reimburse hospitals at far higher rates — often linked to Medicare and averaging about 2.5 times Medicare from 2020 through 2022. Therefore, as a result of the impact and influence of government payment policies (including defining hospitals' infrastructure and services), hospitals make larger margins from private payers.[147]

### Medicaid: Inpatient and Outpatient Services

***Description.*** Medicaid pays hospitals for inpatient and outpatient services through FFS and managed care programs. Most beneficiaries are enrolled in managed care, and many states use SDPs and rely overwhelmingly on federal resources to increase hospital payment rates to levels approaching average commercial rates.

***Benefit to hospitals.*** Medicaid payments to hospitals totaled about **$319 billion in 2024**, including both FFS Medicaid and managed care plans (including the indirect subsidies described).[148] This spending is driven by generous federal matching payments to states, which have been amplified by increased use of state financing gimmicks to pay for large SDPs. Through SDPs — which are revenue-maximization schemes that significantly increase federal spending on hospitals without matching state contributions — hospitals are now receiving higher reimbursement, in some cases close to average commercial rates that are more than twice Medicare levels.[149] This has transformed Medicaid into a lucrative payer for hospitals in many states. SDPs reached $110 billion in 2024.[150]

Further, hospitals also benefit from supplemental payments that Congress has added to the program over the years. In 2022, supplemental payments to hospitals accounted for 53 percent of FFS Medicaid.[151]

### Children's Health Insurance Program (CHIP)

***Description.*** CHIP provides coverage to children in families with incomes above Medicaid eligibility. States administer CHIP with federal matching funds, and hospitals are reimbursed for services to CHIP enrollees.

146 CMS, "NHE Fact Sheet," Table 7.

147 Whaley et al., "Prices Paid to Hospitals by Private Health Plans."

148 CMS, "NHE Fact Sheet," Table 7.

149 Blase and Kleinworth, "Addressing Medicaid Money Laundering."

150 Blase and Kleinworth, "Addressing Medicaid Money Laundering," 3.

151 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," Figure 1.

***Benefit to hospitals.*** CHIP hospital spending was about **$7.8 billion in 2024**.[152] CHIP overpayments were $1.4 billion.[153]

### ACA Premium Tax Credits

***Description.*** The ACA provides premium tax credits for most individuals purchasing insurance through the exchanges. These subsidies reduce out-of-pocket costs and expand the number of people with health insurance.

***Benefit to hospitals.*** ACA tax credits totaled about **$130 billion in 2025**.[154] Because insurers can pass nearly all premium increases along to taxpayers, the subsidies encourage less efficient plans and inflate overall health care spending. Hospitals capture a large share of this added spending through higher utilization and prices.

## Private Consumption Supported by Government

### Employer-Sponsored Insurance (ESI) Tax Exclusion

***Description.*** Employer contributions for health insurance premiums are excluded from employees' taxable income. This tax preference encourages more generous coverage and higher enrollment in employer-sponsored plans.

***Benefit to hospitals.*** The combined tax benefit from lowering income and payroll taxes from the ESI tax exclusion was estimated to be about **$414 billion in 2025**.[155] By reducing the after-tax cost of health insurance, it increases expenditures for people with ESI by about 9.5 percent.[156] In other words, Americans would have bought about $150 billion less health insurance in 2024 — and likely about $50 billion less hospital-based care — than the $1.6 trillion they and their employers actually spent.[157] This distorted incentive for insurance drives higher overall health care spending. Hospitals benefit as the largest segment of health expenditures, capturing increased demand for inpatient and outpatient services at higher prices.

152 CMS, "Historical," National Health Expenditure Data, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

153 CMS, "Fiscal Year 2025 Improper Payments Fact Sheet," January 15, 2026, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet.

154 Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2024-2028*, December 11, 2024, https://www.jct.gov/getattachment/765709fb-9a4b-430a-8f9e-4d342ec97f7e/x-48-24.pdf.

155 CBO, "Details About Baseline Projections for Selected Programs," June 2024, https://www.cbo.gov/data/baseline-projections-selected-programs#6.

156 Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," *American Economic Review* 93, no. 4 (2003): 1373–1384, https://doi.org/10.1257/000282803769206359.

157 CMS, "NHE Fact Sheet."

## Indirect Government Subsidies

### Medicare: Graduate Medical Education (GME)

***Description.*** Medicare reimburses teaching hospitals for a portion of the direct and indirect costs of residency training programs. These payments cover resident salaries, supervising faculty, and institutional overhead.

***Benefit to hospitals.*** Medicare GME funding totaled about **$21.2 billion in 2023**.[158] These payments are meant to offset the expense of training residents. However, these residents are profitable to hospitals even without GME payments covering the cost of employing and training them. They are paid well below the value of the services they deliver. MedPAC estimates that the cost to hospitals of training residents in the largest GME program is less than half the payments hospitals receive.[159]

### Medicare: Disproportionate Share Hospitals (DSH) Payments

***Description.*** Over 40 percent of hospitals receive DSH payments through a calculation of their proportion of patients with Supplemental Security Income or Medicaid.[160] Hospitals can qualify based on the proportion of Medicaid and Supplemental Security Income patients served. Hospitals for which this formula results in a percentage greater than 15 percent are eligible for DSH payments. An alternative method is used by large urban hospitals that can demonstrate that more than 30 percent of their inpatient revenue comes from state and local governments for indigent care (other than Medicare or Medicaid).[161]

***Benefit to hospitals.*** Medicare DSH payments amounted to about **$15.7 billion in 2025**.[162] They directly increase the revenue of safety-net and large urban hospitals. Over 40 percent of hospitals receive Medicare DSH payments.[163]

### Medicare: Uncompensated-Care Payments

***Description.*** Medicare pays hospitals for uncompensated care, which includes both charity care and bad debt.

158 Marco A. Villagrana, "Medicare Graduate Medical Education, 2025," Congressional Research Service, August 20, 2025, https://www.congress.gov/crs-product/IF13088.

159 MedPAC, *June 2021 Report to the Congress: Medicare and the Health Care Delivery System*, June 15, 2021, 215, https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

160 MACPAC, "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States," in *March 2024 Report to Congress on Medicaid and CHIP*, March 2024, https://www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/.

161 CMS, "Disproportionate Share Hospital (DSH)," https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh.

162 Suzanne Condespote et al., "Estimate of Medicare DSH Payments Used in Development of Factor 1," CMS, July 31, 2025, https://www.cms.gov/files/document/fy-2026-final-rule-oact-memo-dsh-factor-1.pdf.

163 CMS, "Disproportionate Share Hospital (DSH)."

***Benefit to hospitals.*** Medicare uncompensated-care payments were about **$5.9 billion in 2024.**[164] By covering part of this bad debt, the program strengthens hospital balance sheets and reduces the impact of uncollected revenue.

### Medicaid: Upper Payment Limit (UPL) Supplemental Payments

***Description.*** The goal of UPL payments is to cover the difference between FFS base payments and payments that Medicare would have paid for the same service.[165] Although initially tied to FFS programs, many states now use similar structures within managed care through SDPs. UPL payments are based on the difference between Medicaid base FFS payments to a class of providers (in the aggregate) and an upper payment limit specified in regulation. For most institutional providers, such as hospitals and nursing facilities, the UPL is defined as a reasonable estimate of the amount that would have been paid in the aggregate for the same service under Medicare payment principles.

***Benefit to hospitals.*** UPL payments have been estimated at about **$15.8 billion across 35 states** in 2022.[166]

### Medicaid: Disproportionate Share Hospitals (DSH) Payments

***Description.*** Medicaid requires states to make DSH payments to hospitals that serve large numbers of Medicaid and uninsured patients. Forty-seven states administer these payments.

***Benefit to hospitals.*** Medicaid DSH payments amounted to about **$12.6 billion in 2024.**[167] They provide direct fiscal support to safety-net institutions with large number of Medicaid and uninsured patients, with a formula locked in for more than three decades that provides disproportionate funding in states that most took advantage of the program early on and thus does not effectively distribute money to where it is most needed.[168]

### Medicaid: Uncompensated Care Pools

***Description.*** Some states operate uncompensated care pools, often under federal waivers, to reimburse hospitals for services provided to uninsured or underinsured patients.

***Benefit to hospitals.*** Uncompensated care pools distributed about **$10 billion across seven states** in 2022.[169] These pools convert otherwise uncompensated care into revenue streams.

164 MedPAC, *Medicare Payment Policy*, March 2026, 81.

165 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," 6.

166 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," Table. 1.

167 MACPAC, *MACStats: Medicaid and CHIP Data Book*, December 2024, 63.

168 Brian Blase, "Punishing Conservative States: Payment Cuts to Hospitals Where Federal Spending Is Already Low," Paragon Health Institute, December 2021, https://paragoninstitute.org/medicaid/punishing-conservative-states/.

169 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," Table. 1.

### Medicaid: Graduate Medical Education (GME)

***Description.*** States often provide GME payments through Medicaid to cover residency training costs not financed by Medicare. These payments support both direct and indirect educational expenses.

***Benefit to hospitals.*** Medicaid GME funding totaled about **$4.9 billion across 35 states in 2022**.[170] These payments are meant to reduce the cost burden of training new physicians, especially in hospitals that serve large Medicaid populations. Although Medicaid GME funding may be profitable to some hospitals, the program has long been recognized as operating very opaquely.[171]

### 340B Drug Pricing Program

***Description.*** The 340B program requires drug manufacturers to sell outpatient drugs at steep discounts to eligible tax-exempt hospitals and other providers. Hospitals can acquire drugs at prices well below their standard acquisition costs and then bill at a much higher rate for delivering the drugs.

***Benefit to hospitals.*** Discounted purchases under 340B were valued at about **$53.7 billion in 2022**,[172] growing to about **$81.4 billion in 2024**.[173] This program functions as a significant indirect subsidy, providing tens of billions of dollars in additional hospital revenue annually. The 340B program also leads to increased consolidation, with hospital systems buying 340B-covered entities.

## Programs Specifically Benefiting Rural Hospitals

A complex of subsidies props up hospitals in rural America.

Wage-index exceptions are especially targeted at rural hospitals. These place an artificial floor on any geographic adjustment to the wage index, and these exceptions were $2.2 billion (2022). These adjustments are budget neutral and thus reduce payments to other hospitals. Non-budget-neutral adjustments amounted to $314 million (2022).[174]

170 MACPAC, "Medicaid Base and Supplemental Payments to Hospitals," Table. 1.

171 Committee on the Governance and Financing of Graduate Medical Education, *Graduate Medical Education That Meets the Nation's Needs* (Institute of Medicine of the National Academies, 2014), 8, https://www.nationalacademies.org/read/18754/chapter/1.

172 Adam J. Fein, "Exclusive: The 340B Program Reached $54 Billion in 2022 — Up 22% vs. 2021," Drug Channels, September 24, 2023, https://www.drugchannels.net/2023/09/exclusive-340b-program-reached-54.html.

173 Adam J. Fein, "340B Hit $81 Billion in 2024 (+23%): Why CMS and the IRA Are Poised to Cool the Program's Runaway Growth," Drug Channels, December 15, 2025, https://www.drugchannels.net/2025/12/340b-hit-81-billion-in-2024-23-why-cms.html.

174 MedPAC, *June 2023 Report to the Congress: Medicare and the Health Care Delivery System*, June 15, 2023, 383, https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

The Health Resources and Services Administration made $70 million in grants to rural hospitals in 2023 to improve financial performance, quality, and efficiency and provide technical assistance.[175]

Congress also introduced a new payment designation in 2021, the "Rural Emergency Hospital, (REH)," which is an outpatient department with an emergency department. These hospitals get special fixed payments to compensate for the shift from inpatient to outpatient care. However, the number of these hospitals and related payments are still very small. In 2024, there were 38 REHs. Fixed payments added up to about $100 million that year on top of about $24 million in OPPS payments to REHs.[176] REHs are a cost-effective way to avoid overpaying for hospitals in rural areas while maintaining capacity.

Medicare beneficiaries can also receive care in about 1,350 small hospitals called critical access hospitals (CAHs). In 2023, CAH revenue was $12 billion (which included unspecified beneficiary cost sharing).[177] CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on hospitals' MCRs. Most CAH beds are "swing beds," in which beneficiaries can receive acute or post-acute care. In some states, these beds can also be used for long-term care of Medicaid patients. Medicare pays these hospitals 101 percent of their facility costs and 115 percent of the PFS amount for professional fees for physicians and non-physicians.[178]

In the 2025 OBBB, Congress included an innovative Rural Health Transformation Fund, a $50 billion grant program targeted at states, that runs for five years. Importantly, the fund shifts from funding *rural hospitals* to funding *rural health care* — an important distinction that will allow innovative providers which have better incentive to gain market share in rural America.[179] Even if saving rural hospitals were a worthy goal in itself, expert analysis estimates achieving that goal would cost only $3.2 billion a year. As this paper demonstrates, there are plenty of savings elsewhere in the health system if Congress wanted to go in that direction.[180]

175 Health Resources and Services Administration, "Fiscal Year 2023 Federal Office of Rural Health Policy Investments," November 2023, https://www.hrsa.gov/sites/default/files/hrsa/rural-health/resources/hrsa-2023-rural-health-investment.pdf.

176 MedPAC, *Medicare Payment Policy*, March 2026, 88.

177 MedPAC, "Critical Access Hospitals Payment System," revised November 2025, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_CAH_FINAL_SEC.pdf.

178 CMS, "Information for Critical Access Hospitals," December 2025, https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf.

179 Finerfrock, "Rural Health Transformation Fund."

180 Center for Healthcare Quality and Payment Reform, "How to Prevent Rural Hospital Closures," https://ruralhospitals.chqpr.org/Solutions.html#the-need-for-rapid-action-to-prevent-closures-and-sustain-rural-healthcare.

# PART 5: HOW THE GOVERNMENT UNDERMINES COMPETITION

This section provides more detail on how some of these government programs lead to higher hospital prices and expenditures.

## Traditional FFS Medicare: Excessive Payments to Hospital Outpatient Departments

As discussed earlier, Medicare significantly distorts the health care sector by paying much more for the same services provided in an outpatient department as provided in doctors' offices or ASCs. Hospitals have leveraged this differential by acquiring more physician practices and ASCs and turning them into outpatient departments to capture these higher rates. In 2008, for instance, Medicare FFS spent $40.1 billion on outpatient services versus $88.4 billion on physician and other medical services. By 2023, the cost of outpatient services had *doubled* to $83.8 billion. In comparison, the cost of physicians and other medical services grew by only 43 percent to $126.3 billion over the same period.[181]

Hospital outpatient departments are also disproportionately associated with improper Medicare payments compared to physicians' offices.[182] CMS listed hospital outpatient services — but *not* independent physicians' services — as a significant source of overpayments.[183]

This shift to outpatient services (as shown in Figure 6) will likely continue. CBO projects that traditional FFS Medicare's hospital inpatient spending will rise from $145 billion in 2023 to $217 billion in 2034 — a 50 percent increase. Over the same period, CBO projects that hospital outpatient spending will *triple* that growth rate, going from $65 billion in 2023 to $161 billion in 2034 — a 148 percent increase. CBO projections for the growth in Medicare spending on physician services from 2023 to 2034 are far more modest, increasing from $71 billion to $87 billion, an increase of 23 percent.[184] Shifting care to outpatient sites makes sense for patient convenience. However, the current payment system of higher payments at identical facilities

181 CMS, "CMS Program Statistics — Medicare Part A and Part B — All Types of Service," January 30, 2026, https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-service-type-reports/cms-program-statistics-medicare-part-a-part-b-all-types-of-service.

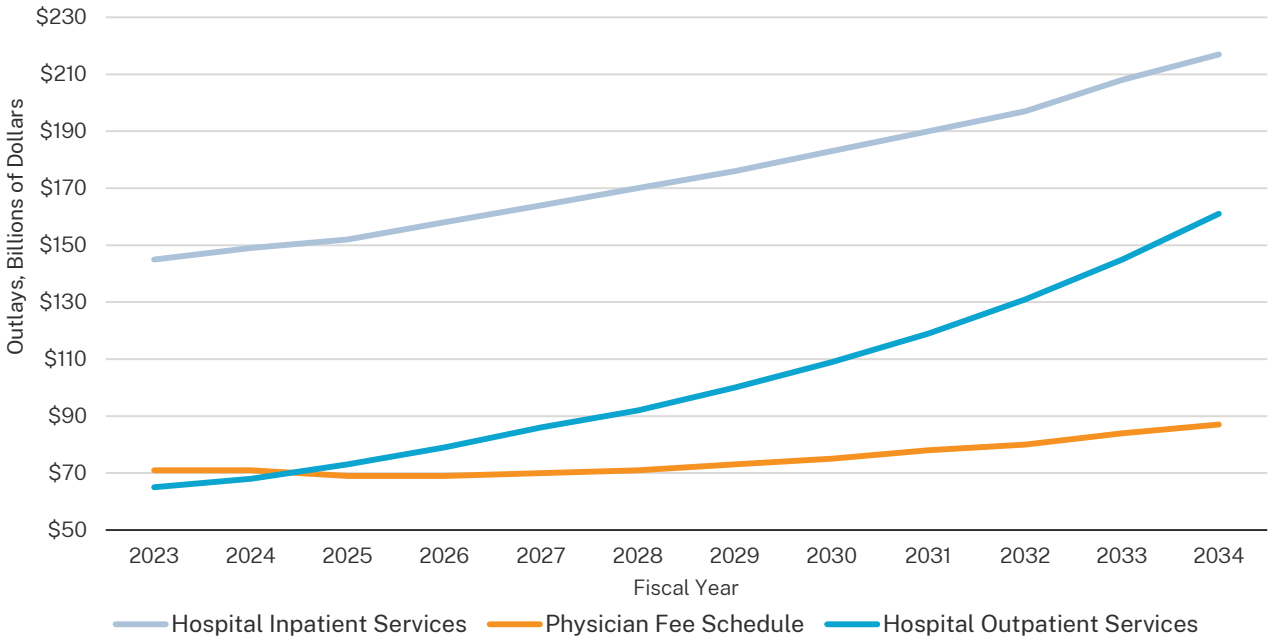
182 Rachel Greszler, "How Congress Can Help DOGE Reduce Improper Payments," Economic Policy Innovation Center, February 3, 2025, https://epicforamerica.org/social-programs/how-congress-can-help-doge-reduce-improper-payments/.

183 *Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS), 2024 Q4*, Payment Integrity Scorecard (Office of Management and Budget (OMB), 2024), https://paymentaccuracy.gov/assets/scorecards/Q4%202024/Centers%20for%20Medicare%20&%20Medicaid%20Services%20(CMS)%20-%20Medicare%20Fee-for-Service%20(FFS).pdf.

184 CBO, "Baseline Projections — Medicare," June 2024, www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf.

## Figure 6: Hospital Outpatient Spending Projected to Increase Six Times Faster Than Physician Fees, 2023-2034

Hospital Inpatient Spending Projected to Remain the Largest Area of Spending Although the Gap is Projected to Close as More Services Projected to Move to Outpatient Settings




SOURCE: Congressional Budget Office, Baseline Estimates, June 2024, https://www.cbo.gov/data/baseline-projections-selected-programs.

for identical services after the acquisition means that taxpayers and Medicare beneficiaries are not benefiting from the savings that should accrue from this shift.

## Corporate Welfare to Hospitals Through Medicaid Money Laundering

Another area where government policies distort competition and lead to abuse is the legalized state Medicaid money laundering schemes, which allow states and health providers, particularly hospitals, to profit by multiplying federal financing without any actual state contributions. Universal Health Services, for example, reaped nearly $1 billion through such arrangements in 2024, while North Carolina's Atrium Health was projected to collect $1.7 billion in 2025.[185] Under this financing scheme, health care providers send money to states through a provider tax. States then use those funds to increase Medicaid spending using federal matching dollars. The providers benefit from higher payments for services they provide to Medicaid recipients. In many states, these payments to hospital systems approach

185 Jonathan Weil, "Hospital Chains' Medicaid Profits Are a Juicy Target for GOP Budget Hawks," *Wall Street Journal*, April 20, 2025, https://www.wsj.com/health/healthcare/medicaid-hospital-profit-republican-budget-cuts-f6a52407; Blase and Kleinworth, "Addressing Medicaid Money Laundering," 35.

average commercial rates, which, as discussed above, average 2.5 times Medicare rates.[186] For hospitals, excessive Medicaid payments exacerbate administrative bloat and inefficiency.

Further, hospitals have an easy on-ramp to receiving excessive Medicaid payments through hospital presumptive eligibility (HPE). Passed by Congress in 1986, HPE allowed hospitals to consider pregnant women "presumptively eligible" for Medicaid while their eligibility applications were under review. Later, this flexibility was extended to other enrollees. Although 70 percent of people granted HPE are eventually deemed ineligible, taxpayers cannot recoup the monies already spent.[187]

## 340B Distortions and Prescription Drug Price Arbitrage

Another government policy that tilts the field of competition toward hospitals is drug reimbursement. Medicare reimburses hospital outpatient departments at a significantly higher rate than when the drugs are administered in a physician's office.

These price differences are most egregious when hospitals make purchases through the federal 340B Drug Pricing Program, which functions as a major subsidy for tax-exempt hospitals. The 340B program requires drug makers, as a condition of having their products paid for by Medicare and Medicaid, to offer "covered entities" reduced prices on drugs. The reduced prices are typically around 25–50 percent below the average wholesale price.[188]

Tax-exempt hospitals make money through the 340B Program by buying drugs at the discounted price and then getting paid for administering those drugs through Medicare or commercial insurance at the market price. This means that hospitals are selling drugs they acquired at steep government-driven discounts to Medicare patients at standard Medicare formula prices: ASP plus 6 percent. (Hospitals are also paid a facility fee as part of the OPPS payment, though CMS implemented site-neutral payments for off-campus HOPDs in the 2026 OPPS final rule.) Under this policy, hospitals are reaping significant arbitrage profit opportunities from Medicare and seniors, who generally face higher co-pays than they otherwise would. Covered entities, owned by hospitals, can also dispense outpatient drugs that give hospitals arbitrage profits. Further, because of the 340B discount formula, hospitals are incentivized to use more expensive drugs that have higher margins between the discounted prices and what insurers or Medicare will pay. The use of higher-priced drugs

186 Whaley et al., "Prices Paid to Hospitals by Private Health Plans," vii.

187 Sam Adolphsen and Jonathan Bain, "Eligible for Welfare Until Proven Otherwise: How Hospital Presumptive Eligibility Pours Gasoline on the Fire of Medicaid Waste, Fraud, and Abuse," Foundation for Government Accountability, September 21, 2020, 13, https://thefga.org/research/hospital-presumptive-eligibility/.

188 Department of Health and Human Services, Office of Inspector General, *Part B Payments for 340B-Purchased Drugs*, November 2015, https://oig.hhs.gov/reports/all/2015/part-b-payments-for-340b-purchased-drugs/.

increases what patients pay out of pocket as well as insurer costs, which in turn causes higher premiums.[189]

Total purchases for 340B-discounted drugs were $81.4 billion in 2024, whereas the measured list-price value was around $147.8 billion.[190] MedPAC anticipates significant growth in 340B spending.[191] The number of covered entities has *more than quintupled* over than past two decades — increasing from 2,424 in 2005 to 12,279 in 2024, including as a result of the statutory expansions in the ACA.[192]

Further, CBO has concluded that 340B incentivizes vertical consolidation among hospitals and clinics that are 340B facilities.[193] Independent physicians, infusion centers, and cancer clinics do not have access to 340B pricing. When a hospital acquires such a practice or clinic, the hospital benefits from the 340B arbitrage for drugs prescribed or administered at the newly acquired clinic or practice.

## PART 6: HOW GOVERNMENT PROGRAMS CONTRIBUTE TO HOSPITAL INEFFICIENCY

Given the wide array of policies and provisions across multiple government programs that favor hospitals, it is not surprising that hospitals are failing to become more efficient or hold down costs. Instead, hospitals focus on maximizing payments from government and private insurers and lobbying for increased benefits from government.

Government payment programs incentivize hospitals to buy up independent physicians. Government rules incentivize hospitals to prevent competition — including other hospitals — from being built. And in the case of physician-owned hospitals, government rules make it difficult for new hospitals to form. All these policies limit competition, undermine innovation, and keep prices higher than they would otherwise be.

### Higher Medicare Payments for Hospital Outpatient Procedures Cause Inefficiency

The MCR system gives hospitals significant flexibility to allocate operating expenses across inpatient and outpatient facilities. Because Medicare pays a separate facility fee for hospital outpatient procedures, hospitals can collectively allocate costs to outpatient facilities to

189 Jackson Hammond, "340B 101," Paragon Health Institute, September 11, 2024, https://paragoninstitute.org/private-health/340b-101/.

190 Fein, "340B Hit $81 Billion in 2024."

191 MedPAC, *Medicare Payment Policy*, March 2024, 74.

192 Hammond, "340B 101."

193 CBO, *Growth in the 340B Drug Pricing Program* September 9, 2025, 17, https://www.cbo.gov/publication/60661.

support the argument that they should receive higher payments for the same outpatient services that independent physicians perform at a lower cost — even though those costs are not necessary to operate their outpatient facilities.

As displayed in Figure 6, there is a large and growing divergence between Medicare spending for medical services in hospital-owned outpatient departments and independent physician practices. Obviously, it is in hospitals' interest to maintain this revenue advantage over independent physicians.

Hospitals claim that their outpatient departments serve higher-risk patients and are generally more expensive to run than an independent physician's office is.[194] However, hospital outpatient departments are not paid more for treating higher-risk patients. They are paid more for having higher costs.

The significant historical shift from providing services on an inpatient basis to an outpatient basis is a positive overall development that indicates that providers are increasingly sophisticated at assessing risks and using innovative technologies and practices to keep patients out of hospital admissions. However, by paying a premium for services delivered in hospital outpatient settings rather than in physicians' offices, payers are paying for hospital overhead that is not necessary or even applicable to patient care.

## Stalling Labor Productivity Growth

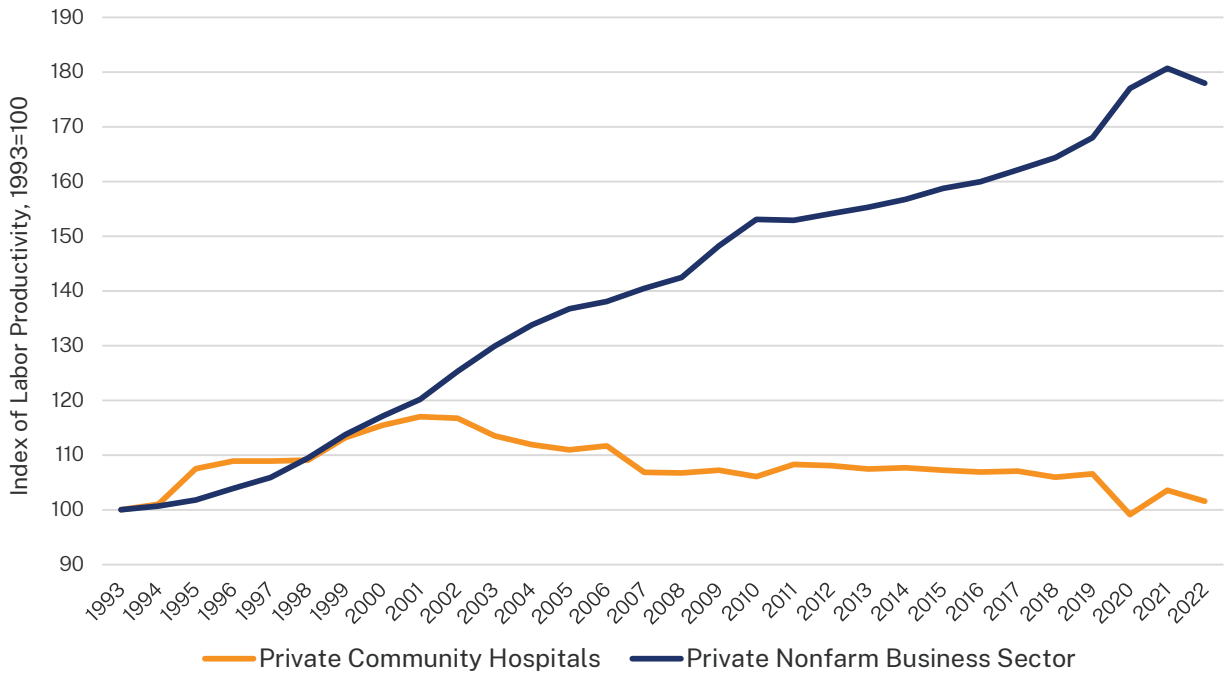
The Bureau of Labor and Statistics (BLS) created an index to measure hospital productivity (see the appendix for more details), which begins in 1993 with an index value of 100. It peaked in 2001 at 115.0 and has declined since then. BLS updated its estimate in 2024, introducing the update with the understatement: "Hospitals: a large, growing, and hard-to-measure industry."[195]

Long-term labor productivity in private community hospitals over the history of the series from 1993 to 2021 grew by an average of 0.2 percent per year. Breaking that time into sub-periods reveals three trends: an era of productivity growth from 1993 to 2001 (2.0 percent annually) followed by productivity decline from 2001 to 2007 (-1.5 percent annually) and finally a period of small productivity decline from 2007 to 2021 (-0.1 percent annually).

194 AHA, "Estimated Impact of Hospital On-Campus and Off-Campus Site-Neutral Proposal," May 2025, https://www.aha.org/fact-sheets/2025-05-08-fact-sheet-estimated-impact-hospital-campus-and-campus-site-neutral-proposal.

195 BLS, "Private Community Hospitals Labor Productivity," June 27, 2024, https://www.bls.gov/productivity/highlights/hospitals-labor-productivity.htm.

## Figure 7: American Labor Productivity Increased 78 Percent Over Last Three Decades Compared to Virtually No Change in Hospital Labor Productivity




SOURCE: Author's analysis of Bureau of Labor Statistics. "Private Community Hospitals Labor Productivity," June 27, 2024, and "Annual Total Factor Productivity and Related Measures for Major Industries. " Washington, DC: Bureau of Labor Statistics, December 4, 2024.

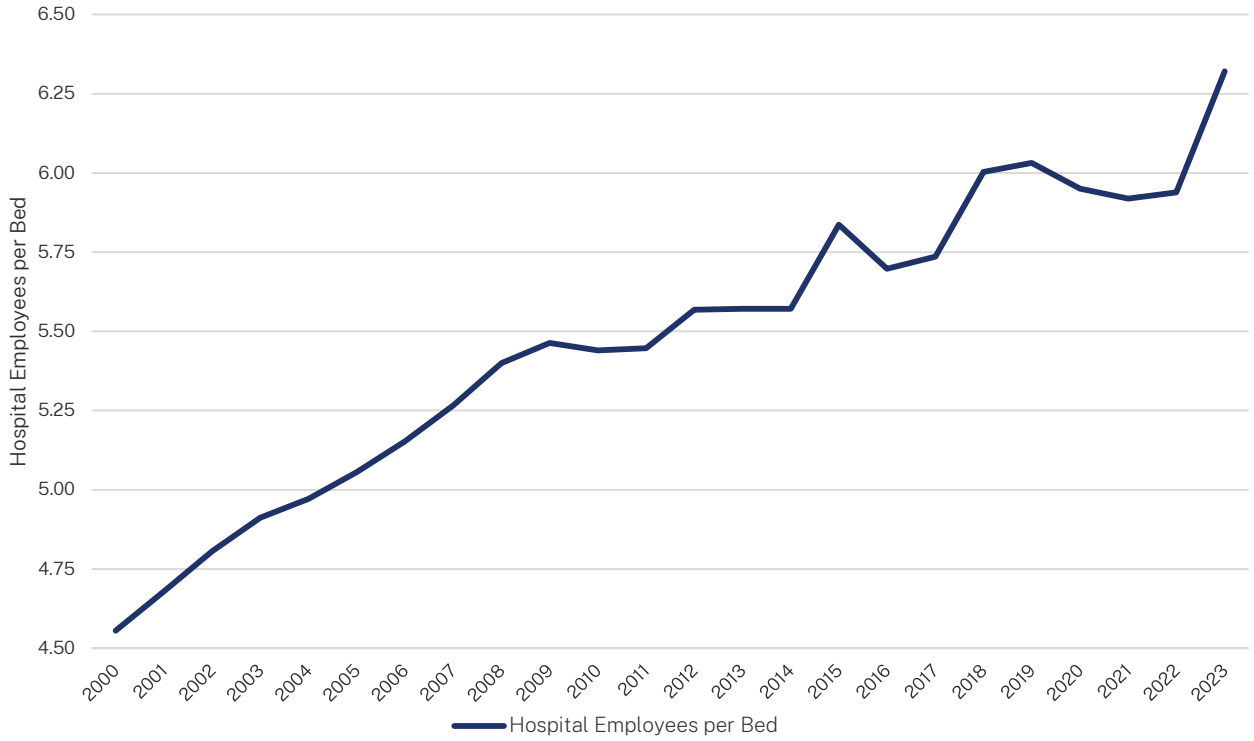
The private nonfarm business sector, on the other hand, increased its productivity by 78 percent over the same period, as shown in Figure 7.[196] Figure 7 does not indicate that hospitals and the private nonfarm business sector were equally productive in 1993 and then diverged. The indexes are composed differently. Figure 8 simply shows that since BLS devised a measure of hospital productivity, hospitals have dramatically failed to improve labor productivity the way other sectors of the market economy have.

To complement our understanding of hospitals' poor productivity, this paper also examines the number of hospital employees per bed.

Although there are no time series showing the proportion of clinical to non-clinical hospital employees, or supervisory to non-supervisory employees, there is a time series of hospital employees. Figure 8 displays the number of hospital employees per bed from 2000 through 2023. As closely as possible, this time series of hospital employees includes only those

196 BLS, "Annual Total Factor Productivity and Related Measures for Major Industries," December 4, 2024, https://www.bls.gov/productivity/tables/.

## Figure 8: Hospital Employees per Bed Grew 39 Percent, 2000-2023




SOURCE: Author's analysis of data from Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, DQS Community hospital beds by state: United States; U.S. Bureau of Labor Statistics via FRED, Employment in General Medical and Surgical Hospitals (NAICS 622110); The World Bank, Population, total - United States.

focused on inpatient tasks and excludes those who perform tasks in offices where physicians do outpatient procedures.[197]

Over the period, the number of employees per bed increased from 4.56 to 6.32, an increase of 39 percent. One possible explanation is that hospitals are adding more employees who do not add value, thereby explaining part of the loss of productivity in the sector. Another explanation is that as more treatments shift to outpatient settings, inpatient admissions increasingly involve more complex cases that require greater attention and resources.

197 With respect to economic statistics, both independent physician practices and hospital-owned practices are categorized in the North American Industry Classification System (NAICS) as NAICS 621111 ("Offices of Physicians Except Mental Health Specialists"). Whereas NAICS 622110 "General Medical and Surgical Hospitals" provide inpatient beds, NAICS 621111 establishments usually provide other services, such as "outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services." NAICS 621493 ("Freestanding Ambulatory Surgical and Emergency Centers") is not so useful because it combines two different types of businesses. See Census Bureau, "Introduction to NAICS," https://www.census.gov/naics/?99967.

# PART 7: HOSPITALS: THE GOOD AND THE BAD

## What Efficient Hospitals Teach Us

Although the hospital industry constantly lobbies for more subsidies, there is evidence that hospitals respond to cost pressure and increase profits across all payers by increasing efficiency. This has profound positive implications and should encourage government cost-cutting efforts. In 2014, the executive director of MedPAC recognized this, remarking:

> MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied through payment rates. We find that providers under cost pressure have lower costs than those under less pressure, and Commission analysis demonstrates that providers can provide high-quality care even while maintaining lower costs relative to their peers.[198]

As discussed earlier, hospitals' Medicare margins consistently appear negative, but many hospitals earn money on Medicare. According to a recent study by Third Way that examined individual hospitals' financial statements, *more than half* of hospitals made money on Medicare in 2022, and one-third made money on Medicaid.[199] The proportion of hospitals that turn a profit on Medicaid has certainly increased since 2022, as hospitals have enjoyed rates that are approaching 2.5 times Medicare rates in some states.[200] These hospitals keep operating costs down and focus on health outcomes. The hospitals making money on public programs also provide more in charity care, contributing 2.2 percent of net revenue, while hospitals losing money on Medicare contribute 1.8 percent of net revenue.

The study concluded that hospitals that make money on Medicare succeed by containing costs and improving outcomes. In other words, successful hospitals focus on efficiency. When hospital leadership drives cost containment and improved outcomes, hospitals are higher quality and lower cost.

## Taking on Hospitals' Arguments

This section includes responses to hospital associations' main arguments to justify their high prices and costs, which they have constantly promoted since the federal government expanded its control over American health care.

198 Mark E. Miller, "Context for Medicare Payment Policy and Recommendations," testimony before the Subcommittee on Health of the House Committee on Energy and Commerce, 113th Congress, December 9, 2014, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/congressional-testimony/testimony-context-for-medicare-payment-policy-and-recommendations-energy-and-commerce-.pdf.

199 Kendall and Wooford, "Tale of Two Hospitals."

200 Blase and Kleinworth, "Addressing Medicaid Money Laundering," 3, 13.

## Argument #1: High overhead costs increase care efficiency and quality.

The AHA has previously sought to explain away high overhead costs by emphasizing that these expenditures are necessary to improve efficiency and quality of care:

> Hospitals also are spending more on things that are not direct patient care services but are still critical to delivering care and maintaining operations. For example, the costs associated with implementing, maintaining and upgrading information management systems and overall technology infrastructure, while critical to improving efficiency and quality of care, typically represent significant investments.[201]

Any overhead expenditures intended to improve efficiency and quality of care should show up as measurable results, reducing total costs within a reasonable period. In competitive industries, such investments are reflected in measurable productivity gains, lower unit costs, or improved output quality over time — benchmarks that hospital spending on overhead has consistently failed to meet. Returning to Figure 1: Cars, clothing, and TVs are examples of goods that have reduced in real price over the years. Production of all these goods involves information management systems, technology infrastructure, and other overhead costs as in the hospital industry. Nevertheless, in these industries such investments reduce, not increase, costs and thus prices.

## Argument #2: High overhead costs are necessary to deal with insurance prior authorization and claim denials.

The AHA also argues that high administrative costs are a consequence of health insurers' increasing prior authorizations and denials, which hospitals often appeal.[202] The AHA cites estimates that hospitals spent $25.7 billion in 2023 on claims adjudication, of which $18 billion was "potentially unnecessary" and wasted on claim denials that were ultimately overturned and paid.[203]

*Potentially unnecessary* is a meaningless term. Whenever insurers control payment, they must impose some friction on claims. Without some claims processing bureaucracy in a third-party payment system, there would not be limits to cost growth. While a large number, even $18 billion of "potentially unnecessary" spending on claims adjudication amounts to little over 1 percent of the $1.56 trillion spent on hospitals that year.

201 AHA, "Costs of Caring," 5.

202 AHA, "Costs of Caring," 4.

203 Michael J. Alkire et al., "Claims Adjudication Costs Providers $25.7 Billion — $18 Billion Is Potentially Unnecessary Expense," Premier, February 24, 2025, https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense.

Further, the increasing automation of health records has led to a boom in revenue cycle management businesses — an industry that is growing 13 percent annually.[204] Hospitals are now able to pump claims aggressively into the system at rapid speed. Insurers cannot be expected to simply process all these claims without investigation.

## Argument #3: Any reforms that reduce hospital funding will negatively impact safety and quality.

Taken together, the evidence does not support the claim that higher hospital spending or broader subsidies reliably translate into better outcomes. If anything, government-driven consolidation and higher payments are more consistently associated with higher prices and, at best, ambiguous effects on quality.

A 2017 analysis found that "there is an overwhelming lack of literature in this area."[205] A more recent review of 50 studies that analyzed hospitals in the United States concluded that a "clear trade-off between these two dimensions is rather unlikely." Although it did admit that evidence "points in the direction of a positive relationship" between hospital financial performance and quality of care.[206]

A study covering the period 2013-2017 and including almost 5 million patient-years showed no improvement in patient outcomes at hospitals when they employ primary care physicians.[207]

With respect specifically to hospital ownership of outpatient departments, a 2024 review of 43 studies of hospital-physician vertical integration found the effect on quality to be ambiguous but confirmed that prices increase.[208] Another study, covering 2008-2015, found that the effect of vertical integration on clinical quality was limited. However, the effect of vertical integration on 10 patient satisfaction measures was *negative*, with statistical significance.[209]

204 AHealthcareZ — Healthcare Finance Explained, "Revenue Cycle Management in Healthcare Explained," YouTube, April 14, 2024, https://www.youtube.com/watch?v=rqdWr9ynZ_o.

205 Matthew Barnes et al., "Exploring the Association Between Quality and Financial Performance in U.S. Hospitals: A Systematic Review," *Journal of Health Care Finance* 44, no. 2 (2017): 2, https://healthfinancejournal.com/index.php/johcf/article/view/144.

206 Katarzyna Dubas-Jakóbczyk et al., "The Association Between Hospital Financial Performance and the Quality of Care — A Scoping Literature Review," *International Journal of Health Policy and Management* 11, no. 12 (2022): 2816–2828, https://doi.org/10.34172/ijhpm.2022.6957.

207 Katherine M. Ianni et al., "Quality-of-Care Outcomes in Vertical Relationships Between Physicians and Health Systems," *JAMA Health Forum* 5, no. 8 (2024): e242173, https://doi.org/10.1001/jamahealthforum.2024.2173.

208 Alexandra Harris et al., "Cost, Quality, and Utilization After Hospital-Physician and Hospital-Post Acute Care Vertical Integration: A Systematic Review," *Medical Care Research and Review* 82, no. 1 (2025): 3–42, https://doi.org/10.1177/10775587241247682.

209 Marah Noel Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* 77, no. 6 (2020): 538–548, https://doi.org/10.1177/1077558719828938.

A 2023 literature review compared safety of outpatient procedures for several specialties. The review found that, with the exception of dental surgery, outcomes were not worse in outpatient settings and there was continuous improvement of safety and an understanding among specialists about which risk factors would indicate whether cases should be referred for inpatient admission. The article also noted recent innovations in mobile anesthesia that support the migration of surgical procedures to outpatient settings and allow an anesthesiologist to bring portable equipment into the physician's office that effectively replicates what the anesthesiologist would have in an operating room.[210]

### Argument #4: Subsidizing hospitals supports rural health care.

Hospital lobbyists often argue that, without subsidies, rural health jobs would disappear and access to health care would collapse in rural America.[211] These claims are unfounded. In fact, some evidence suggests the opposite. States with Medicaid provider taxes have smaller health care workforces than do states without them (fewer than five workers per 1,000 residents compared with more than six). Further, this gap increases after the states implement provider taxes.[212] Rather than targeting support to truly vulnerable rural providers, these Medicaid financing schemes disproportionately benefit large hospital systems, encouraging consolidation and administrative expansion while doing little to sustain access in isolated or low-volume communities.

## PART 8: RECOMMENDATIONS

1. Congress should enact site-neutral payment reform in Medicare so that the same payment is made regardless of setting. The Centers for Medicare and Medicaid Services (CMS) should build off its recent actions and use its administrative authorities to advance site-neutral payment reforms, as described in a recent Paragon policy brief.[213] States should advance site-neutral payment reforms in Medicaid. Site-neutral reforms would reduce consolidation incentives, strengthen the program for the future, and deliver savings for seniors and taxpayers.

210 Young et al., "Safety Considerations with the Current Ambulatory Trends."

211 AHA, "Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access," 2025, https://www.aha.org/fact-sheets/2025-06-13-rural-hospitals-risk-cuts-medicaid-would-further-threaten-access.

212 Liam Sigaud and Niklas Kleinworth, "Will Congress' Reforms to Medicaid Financing Hurt Rural Health Care? No: Debunking the Myth That Provider Taxes Support Rural Hospitals," Paragon Health Institute, July 15, 2025, https://paragoninstitute.org/medicaid/will-congress-reforms-to-medicaid-financing-hurt-rural-health-care-no-debunking-the-myth-that-provider-taxes-support-rural-hospitals/.

213 Demetrios L. Kouzoukas and Jackson Hammond, "Advancing Choice, Competition, and Fiscal Sustainability in Medicare: A Roadmap for CMS," Paragon Health Institute, February 11, 2026, https://paragoninstitute.org/medicare/advancing-choice-competition-and-fiscal-sustainability-in-medicare-a-roadmap-for-cms/.

2. CMS should consider modernizing rate setting using Medicare Advantage price transparency data — which is now required to be publicly disclosed — as a proxy for cost and resource use when setting rates or the relativity of rates within the Physician Fee Schedule and hospital outpatient payment systems.[214]
3. Congress should limit Medicaid financing gimmicks that inflate hospital payments and increase federal spending, building on the important reforms in the One Big Beautiful Bill Act that reduced states' ability to use the provider tax scheme and capped Medicaid payment through SDPs at or near Medicare levels. CMS should reject state efforts to increase their use of money laundering tactics to inflate payments to hospital systems. And states should resist pressure from hospital systems to create workarounds to federal law that attempt to gain more federal Medicaid money for their coffers.
4. CMS should conduct better oversight of supplemental payments for hospitals, including Disproportionate Share Hospital payments, to inform policymakers on how to rationalize the disparate hospital subsidy streams into a more targeted, sensible structure where funds flow to true safety-net providers. Congress should then enact such reforms.
5. Congress should direct the Government Accountability Office to compile an inventory of all federal hospital payments, including subsidy programs, and provide recommendations on how to simplify and focus overlapping programs and condition future payments and subsidies on quality, efficiency, and financial transparency. Congress should then enact such reforms.
6. Congress and the Trump administration should address distortions in the 340B program by targeting dollars to entities or directly to individuals, in either case based on their need, reducing incentives for consolidation and saving consumers and taxpayer dollars.
7. States should remove regulatory barriers to competition, including by repealing or limiting CON laws. Congress and the administration can encourage this by conditioning federal money on positive reforms. For example, the Rural Health Transformation Fund awards points to states without CON laws, increasing their potential funding.[215]

214 Kouzoukas and Hammond, "Advancing Choice, Competition, and Fiscal Sustainability in Medicare."

215 Bill Finerfrock, "Rural Health Transformation Fund Offers States a Way to Improve Rural Health Care Access: Here's What States Should Do," Paragon Health Institute, October 2025, https://paragoninstitute.org/medicaid/rural-health-transformation-fund-offers-states-a-way-to-improve-rural-health-care-access-heres-what-states-should-do/.

8. Congress should repeal the Medicare payment limitations on physician-owned hospitals included in the Affordable Care Act.
9. In the short term, Congress and the administration should increase oversight of hospitals' compliance with IRS rules. Longer term, Congress should tie tax-exempt status to measurable and actual charity care instead of vaguely defined "community benefit."
10. The federal government should enforce price transparency requirements on both hospital systems and insurers.
11. Congress should remove uncompensated care payments from Medicare, index them to inflation, and base them on a hospital's share of charity care and non-Medicare bad debt.[216]
12. Congress should eliminate GME funding by formula, replacing it with discretionary grants to support residents' education, not hospitals' revenues.

## CONCLUSION

The key to reforming hospital financing is reversing or limiting government policies that inflate costs, prices, and spending without accountability to consumers. It means targeting subsidies based on need, rewarding efficiency, and reforming structural distortions that emanate from government programs.

216 Jackson Hammond, "Medicare Reforms for Reconciliation," Paragon Health Institute, April 30, 2025, https://paragoninstitute.org/medicare/medicare-reforms-for-reconciliation/.

# APPENDIX

## BLS Hospital Productivity Index

The discussion so far indicates that measurements of hospital labor productivity should be difficult to define. Fortunately, BLS developed a measure in 2015.[217] Prior to 2015, BLS had been able to measure labor input, but not output, in health care. For most service industries, BLS uses constant-dollar revenues as output. This makes sense in a competitive market where consumers spend their own money: Higher real prices indicate that services have improved.

However, it would be inappropriate to do this for health care, because patients are generally unaware of relevant pricing. Therefore, BLS developed a measure based on the number of completed treatments. Each inpatient discharge and outpatient visit is assigned a disease and associated cost. Annual changes in the quantity of each disease are weighted by its share in the total value of output. Therefore, those diseases that contribute more to total revenue are given greater weight in the overall output index. The index does not measure quality of output but only if a patient was discharged dead or alive.

To be sure, BLS notes, "As technology in the medical field advances, procedures that once required an inpatient stay can now be performed on an outpatient basis inside or outside the hospital. As a result, remaining inpatient cases being treated by hospitals have become increasingly difficult and complex, requiring more staff attention (greater growth in labor hours worked relative to output)."[218] Nevertheless, this effect is cancelled out in the index because it includes both inpatient and outpatient measures of hospital productivity.

217 Brian Chansky et al., "New Measure of Labor Productivity for Private Community Hospitals: 1993–2012," BLS, October 2015, https://www.bls.gov/opub/mlr/2015/article/new-measure-of-labor-productivity-for-private-community-hospitals-1993-2012.htm.

218 BLS, "Private Community Hospitals Labor Productivity."