Commercial Sector Prices

AV HEALTH CARE FACT SHEET 2026

Health care prices are high and continue to rise. Consumers, patients, and employers ultimately bear the brunt of these prices, as premiums and out-of-pocket costs rise and health care becomes less affordable.

- The average annual premium for an employer-sponsored family plan in 2025 was nearly $27,000, a 52% increase since 2015.[1]
- Average deductibles for workers with single coverage have increased by 43% over the last ten years.[2] The availability of high-deductible health plans in the commercial market grew from 38% in 2015 to 50% in 2024, with around a third of covered workers now enrolled in these plans.[3,4]
- Offering health care benefits is a core value for many employers, but excessively high prices increase employers' health insurance costs and lead them to pass a greater share of these costs onto employees and their families in the form of higher premiums and out-of-pocket costs. 63% of large employers consider high hospital prices to be a significant contributing factor to premium growth.[5]
- Rising health care prices affect employers' ability to offer employee benefits. 90% of large employers say that health care costs will become unsustainable in the next five to ten years if costs are not lowered.[6]
- Economists have found that in recent decades, health care costs have generally outpaced wage growth.[7] In 2025, average premiums for people who get family coverage through their employer increased 6%, compared to 4% wage growth and 2.5% inflation.[8]
- Rising prices depress wages as employers are forced to make tradeoffs between higher wages and the costs of providing health benefits.[9] One analysis found that from 2020–2030, workers across the United States could lose between $18,000 and $25,000 in wages because of rising premiums.[10]

The high prices paid to providers, particularly to large, consolidated hospitals and health systems, are the primary driver of increased health costs and insurance premiums for people with private health insurance.

- Hospital prices tripled between 2000 and 2023, growing faster than other health care categories and three times faster than general inflation over the same period.[11]
- Between 2018 and 2022, average health care prices increased 14% while utilization increased just 4%. During the same period, the average price of inpatient hospital admissions increased by 20%.[12]
- Hospital spending represents more than 30% of overall health care spending.[13] Put another way, for every three dollars spent on health care, one dollar goes towards hospitals.
- Hospital spending also accounts for a larger share of spending growth than other spending categories, representing 40% of the growth in national health spending between 2022 and 2024.[14]
- On average, hospitals charge privately insured patients more than 2.5 times what Medicare pays for the same service, with some hospitals charging over 5 times what Medicare would pay.[15,16,17] The prices that hospitals charge privately insured Americans for care are much higher than the prices paid in public programs, since private payers have less ability to constrain the prices charged by hospitals with substantial market power than government payers do.
- Certain physician specialties are also able to charge excessive prices. For example, anesthesiologists charge privately insured patients 3.3 times what Medicare would pay on average.[18]

- High prices are not limited to for-profit hospitals. One study of commercial claims data found that relative to for-profit hospitals, nonprofit hospitals charged higher prices that grew at a faster rate over time.[19] Further, nonprofit hospitals received $37.4 billion in federal, state, and local tax benefits in 2021 alone, though evidence suggests they are not providing the requisite community benefits to justify these tax breaks.[20,21,22] In some cases, they spend proportionally less than for-profits on charity care and employ aggressive billing and debt collection practices even when patients are eligible for financial assistance.[23,24,25]
- If the prices hospitals charge were limited to 2 times what Medicare pays, premiums and cost-sharing for Americans with private insurance would be reduced by $988 billion over the next decade.[26]

High and rising prices are the result of decades of unchecked consolidation in the health care sector. As large hospitals and health systems consolidate, they gain more market power to charge even higher prices and use anticompetitive business tactics that further limit competition.

- Nearly 90% of health care provider markets are highly concentrated, according to U.S. Federal Trade Commission (FTC) standards.[27] By the same standard, almost 97% of metropolitan inpatient hospital markets are considered highly concentrated.[28]
- As of 2021, 13 health systems accounted for 25% of all US hospital beds.[29,30] A single hospital system accounts for all inpatient hospital discharges in almost 20% of metropolitan areas.[31]
- Numerous studies have documented an increase in commercial health care prices ranging from 3% to as high as 65% following hospital mergers.[32] Not only do merged hospitals increase their prices — their nearby competitors raise their prices as well.[33] In one study, neighboring hospitals increased prices by 5.1%.[34]
- Evidence suggests that merging hospitals prioritize profitable service lines, like intensive care, while at times eliminating less profitable services, such as obstetrics. This shift can displace lower-paying patients to non-merging hospitals, potentially contributing to their financial instability.[35]
- Hospital acquisitions of physician practices increased by over 70% between 2008 and 2016. Following these transactions, prices tend to increase as well.[36,37] One study found that prices for labor and delivery services provided by hospital-acquired physicians increased by 15.1%, largely driven by diminished market competition.[38]
- Cross-market mergers, or mergers between providers in different geographic markets, are becoming increasingly common with more than half of all mergers during 2010-2019 qualifying as cross-market.[39] Evidence shows that prices increased almost 13% in the six years following an acquisition, without quality improvements.[40]

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

- Although provider consolidation results in price increases, it does not result in associated gains in quality. Most studies have shown little to no effect on quality, with some studies even showing that quality decreased.[41,42,43,44,45]
- Consolidated health care markets have been linked to worse health outcomes in some studies.[46,47] One study conducted by the FTC found that when cardiology markets are concentrated, cardiology patients are more likely to have heart attacks, visit the emergency room, be readmitted to the hospital, or die.[48]
- Health care consolidation can limit access to care in rural areas. Evidence suggests that as large systems acquire rural hospitals, they reduce key services such as primary care, obstetrics, neonatal, surgery, and imaging. This can in turn increase wait times and reduce access for patients.[49,50,51,52,53]

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

- 100M Americans are saddled with medical debt. [54] 4 in 10 adults with employer-sponsored health insurance report having problems affording health care.[55]
- Despite major expansions in health insurance coverage in the last decade, more than 3 in 10 adults with commercial coverage in the U.S. report owing medical debt, and over half of medical debt among working-age adults results from care received at a hospital.[56]
- The burden of medical debt is not equally distributed: Black Americans, individuals with disabilities, and those living in the South are most likely to face significant medical debt.[57]
- High prices and the fear of medical debt are prompting more people to put off medical care; more than 3 in 10 commercially insured adults in the U.S. reported cost-related reasons for delaying or forgoing care.[58]

The excessive prices charged to patients are often set arbitrarily, are irrationally high, and have little to do with the cost of providing care.

- Prices vary widely within a given market for the same service. In El Paso, Texas, depending on the provider you visit, prices for the same blood test ranged from $144 to $952. Prices also vary substantially across markets — that same blood test is only $25 in Portland, Oregon.[59]
- In Boston, the price of a vaginal delivery can be $14,615 higher or lower, depending on the hospital.[60] One study found prices vary more within a given health system and within a given state than across systems and states.[61]

While hospitals argue they must charge high prices to privately insured patients to remain afloat, evidence suggests this is often not the case.

- There is significant variation in financial health across hospitals, resulting in “have” and “have-not” facilities. While some hospitals, especially safety-net and rural hospitals, face significant financial threats, many large hospitals and systems have reported strong finances in recent years.
- Nationally, the Medicare Payment Advisory Commission (MedPAC) estimates that hospital operating margins averaged 6.5% in 2024.[62] Using a different methodology, an alternate analysis finds that in the same year, mid-sized to large hospitals with over 100 beds reported a median operating profit margin of 14%, comparable to the operating margin of Disney and more than that of companies like Target and Delta Air Lines.[63,64,65,66]
- Data indicate substantial growth in hospital system assets over time. U.S. hospital assets more than doubled from 2000 to 2019, jumping from $750 billion to $1.6 trillion, and were more concentrated among hospital systems that were already financially strong.[67,68]
- Hospital prices in the private insurance market average 254% of what Medicare would have paid, even though in 2024, hospitals only needed to charge 112% of Medicare for commercial rates to “break even” and cover hospital expenses.[69,70]
- MedPAC analyses have found that hospital expenses rise with prices. When hospitals receive high commercial payments, they have higher costs per patient because they have less incentive to operate efficiently.[71,72,73] Put another way, some of the wealthiest hospitals in the country appear to have the lowest Medicare margins because they have no incentive to be efficient.
- Providers also claim that high prices charged to privately insured patients compensate for lower Medicare / Medicaid reimbursements. Economic evidence overwhelmingly shows that cost-shifting does not occur. Some studies have even found that hospitals lower private insurance prices in response to cuts in government payment rates, which is the opposite of what the cost-shifting theory predicts.[74,75]

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