Setting the Record Straight

A Challenge to Align Hospital Prices with Value

RIBGH
RHODE ISLAND BUSINESS GROUP ON HEALTH

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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Acknowledgment

The National Alliance gratefully acknowledges support from Arnold Ventures for its Hospital Fair Price initiative, which enables coalitions and employers/purchasers to challenge unsustainable hospital prices.

A Call to Tame Unsustainable Hospital Prices

The National Alliance and its member coalitions share a mission to help employers and purchasers deliver affordable, high-quality, equitable healthcare for employees by driving transparent, fair, and competitive markets; effective purchasing; and meaningful policy changes at federal, state, and local levels.

Because powerful hospital systems continue to increase prices, stifle competition, and obscure actual costs, the National Alliance periodically challenges industry claims that attempt to justify high prices.

Annual premiums for employer-sponsored family health coverage rose another 6% in 2025, nearing an astounding $26,993. Workers now pay about $6,850 out of their paychecks, threatening their health and wellbeing. The squeeze is on for 2026 as well, with costs rising twice as fast as inflation—and driven largely by hospital prices, the largest source of US healthcare spending.

While we recognize many health systems are under financial pressure, the reality for employers is that hospital costs make up at nearly half of their spending. We cannot succeed at reducing the backbreaking cost of care without addressing hospital pricing.

Shawn Gremminger
National Alliance
President and CEO

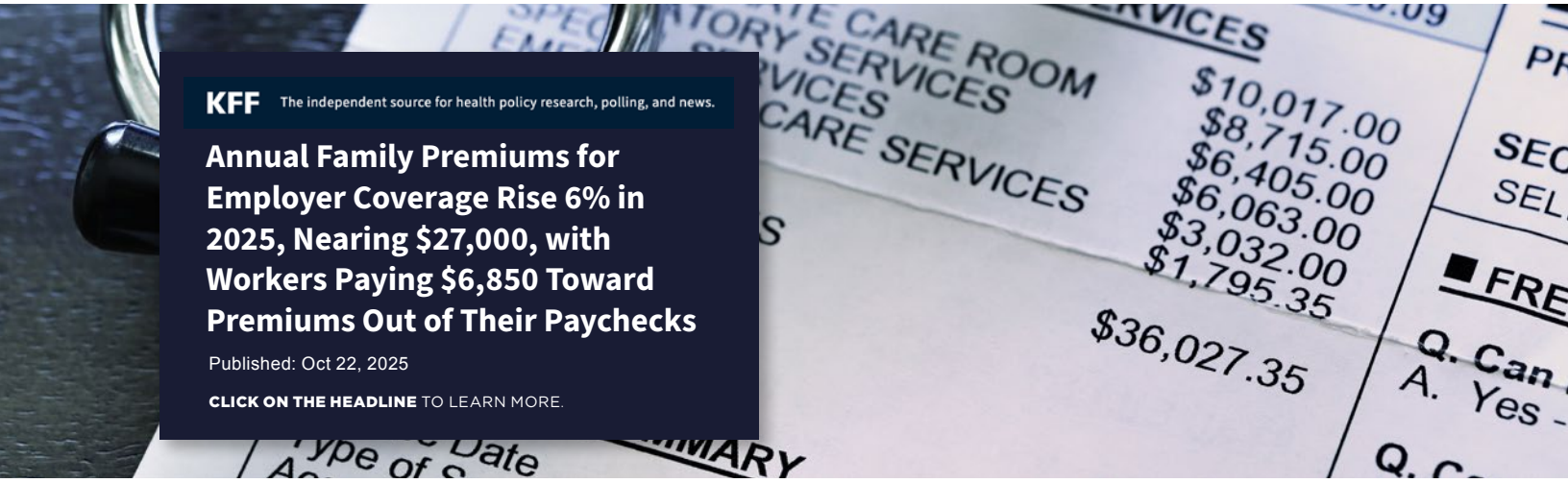
The intent of this report is to set the record straight about what is truly driving hospital costs. Armed with the facts, employers and other healthcare purchasers can set expectations for hospitals to lower unjustifiable costs that translate to less employer innovation, lower wages, higher premiums, worsening whole person health and health equity, and fewer vital community services.

We appreciate that America's hospital and health systems are essential to the nation's health and wellbeing—and that frontline workers are tirelessly and selflessly caring for patients. Let's work together to do the right thing to improve the overall health of employers, consumers, communities, and the economy.

Yours in good faith,

Shawn Gremminger

Shawn Gremminger



Introduction

About half of every dollar an employer spends on healthcare goes to hospital services. Unchecked hospital prices continue rising rapidly, placing growing strain on employers/purchasers and employees.

Working families are struggling to keep up with healthcare costs, with more than 100 million people drowning in medical debt. And nearly half of US adults are worried about their ability to afford care as higher premiums, higher deductibles, and reduced take-home pay take center stage.

As healthcare consumes a larger share of total compensation, fewer dollars remain for wages, benefits, innovation, and workforce investment. This erosion of purchasing power weakens business competitiveness and limits employer ability to attract and retain talent.

The root cause is not inflation, utilization, or patient demand, but hospital consolidation and anti-competitive contracting practices that allow dominant health systems to demand higher prices. Persistent lack of transparency enables these practices to continue largely unchecked.

Hospital services will soon exceed half of all employer healthcare spending and remain the fastest-growing cost category. Without greater accountability and meaningful price reform, these trends will continue to push costs onto employers and workers alike, threatening employer-sponsored coverage.

> *"Transparency data confirms that hospital prices are a major driver of healthcare cost increases. Employers and other plan sponsors routinely pay* ***150%–700% of Medicare rates*** *for hospital services, with a national average of roughly* ***250% of Medicare.*** *These prices far exceed what is necessary to cover costs or ensure quality care."*
>
> **— RAND HEALTH CARE PRICE TRANSPARENCY INITIATIVE**

What is a Fair Hospital Price?

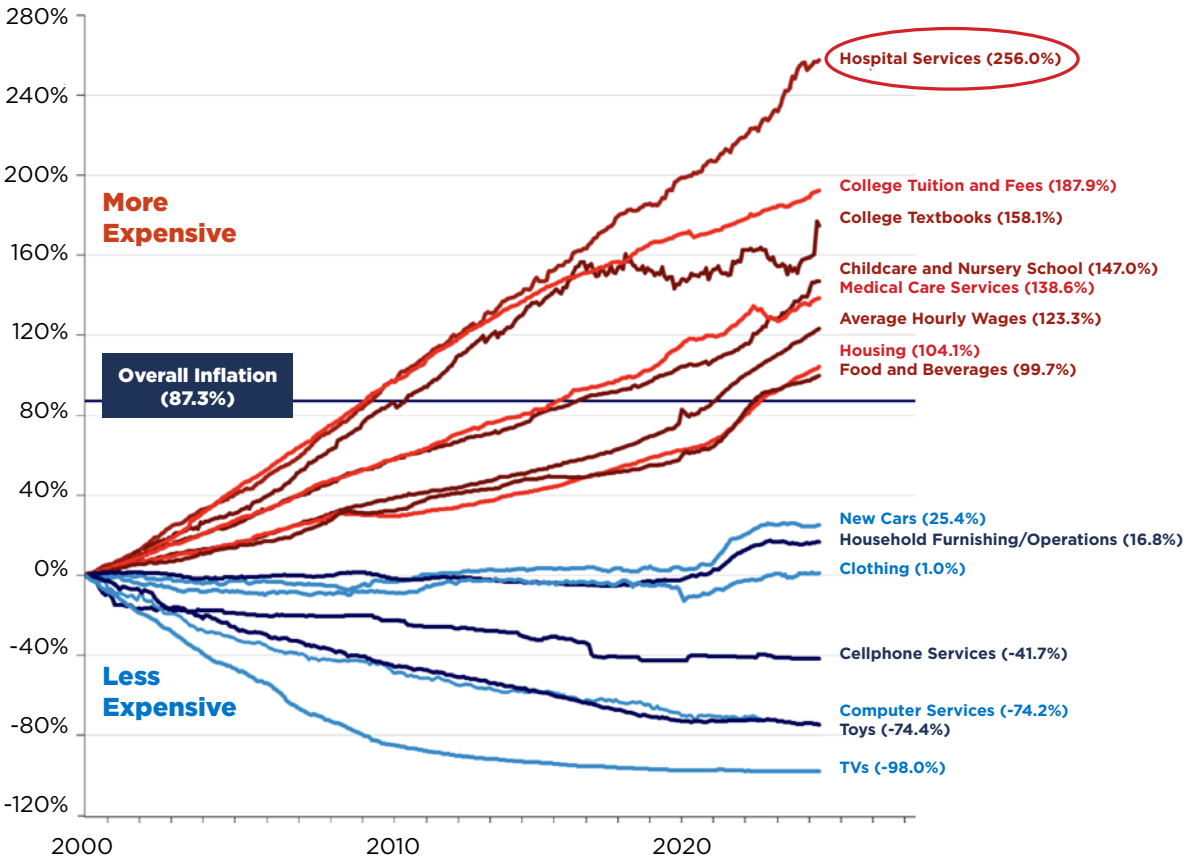
A fair price generally should be between a reasonable markup from costs and a competitive market price for peer hospitals.

If there are normal market competition conditions or effective regulatory oversight, expect to see a price close to a reasonable markup on costs.

140%–200%
of Medicare is what data indicates is a "fair price" for most hospitals.

PRICE CHANGES:
January 2000 to December 2024

Selected US Consumer Goods and Services, Wages



Source: *Bureau of Labor Statistics (Mark J. Perry)*

CLICK ON THE HEADLINE TO LEARN MORE.

PBS NEWS WEEKEND APRIL 12, 2025 5:40 PM EST

Why patients are getting hit with surprise hospital fees for routine medical care

Setting the Record Straight

Myths, below, are from the American Hospital Association's "The Cost of Caring: Challenges Facing America's Hospitals in 2025."

MYTH 1:

Labor costs dominate hospital expenses. Labor costs have surged due to widespread healthcare worker shortages, high reliance on expensive temporary contract labor, and increased wages and benefits for permanent workers.

FACT 1:

Labor costs are a leading cost center for hospitals, but do not justify hospital prices that are two to five times more than Medicare rates—or higher. Data show that hospital prices have risen far faster than labor costs, inflation, and overall hospital expenses. Hospital prices vary widely, even among hospitals with similar labor markets and staffing levels, indicating that price increases are driven less by workforce costs and more by market power, consolidation, and pricing leverage.

> *"In 2023, nonprofit hospital CEOs were paid 12 times the average wage of all hospital workers, with the average CEO salary exceeding $1 million annually [not including benefits like stock options]."*
>
> **— SABRINA WANG, MD**
> **HOSPITAL CEO PAY IS TOO DAMN HIGH**

Moreover, CEO pay is under renewed scrutiny: The five highest paid hospital CEOs take home between $14.4 and $23.5 million in a single year.

Fact 1 Sources: MedPAC Report to Congress, March 2025; U.S. Bureau of Labor Statistics Healthcare Wage Trends, accessed January 2026; RAND: Hospital Price Variations Not Explained by Costs; "What do the Highest-Paid Nonprofit CEOs Have in Common?" Lown Institute, September 2024; "HCA CEO Pay Gap Widens in 2025; The Eye-Popping Compensation of High-Paid Hospital CEOs," Nurse.org, May 2025.

National Alliance Pulse of the Purchaser Survey Reveals Hospital Transparency Concerns

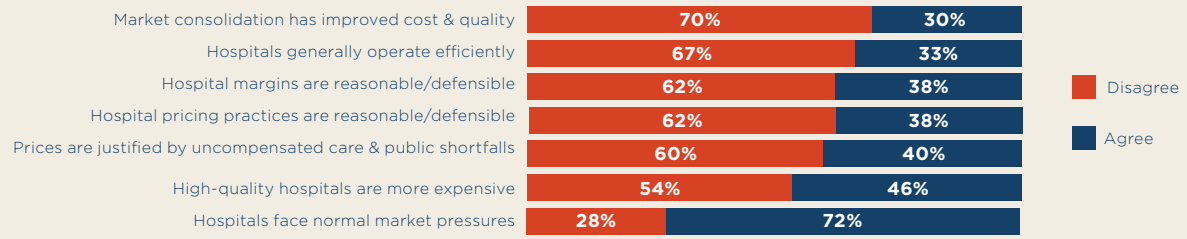
For the fifth straight year, 99% of employers rank drug and hospital prices and high-cost claims as the leading affordability threats.

Drug Prices
86% significant threat
13% minor threat

Hospital Prices
76% significant threat
23% minor threat

High Cost Claims
73% significant threat
26% minor threat

6 out of 10 plan sponsors doubt hospital efficiency, pricing, and benefit of consolidation



Source: National Alliance of Healthcare Purchaser Coalitions 2025 Pulse of the Purchaser Survey

MYTH 2:

High prices are justifiable because hospitals are most often the largest employers in any market, facing associated personnel expenditures, labor costs, and employee-related expenses.

FACT 2:

Hospitals and health systems are large, highly valued employers in many areas, employing about 6.6 million people nationwide. By comparison, however, there are 167 million people employed in the US. Hospitals account for just 4% of all jobs. High and rising prices are reducing wages for the 96% of people who don't work for them.

Fact 2 Sources: AHA: "Hospitals are Cornerstones in Their communities;" Hospital Employment Statistics

Hospital Employment Statistics

4%
Employed by Hospitals

96%
Not Employed by Hospitals

MYTH 3:

Medicare and Medicaid reimbursements are not keeping up with the cost of caring. Payments from Medicare and Medicaid consistently fall below the actual cost of providing care, resulting in substantial shortfalls that must be subsidized. Treating uninsured patients who often turn to emergency departments for care results in increased costs, which acts as a "hidden tax" on the entire system.

FACT 3:

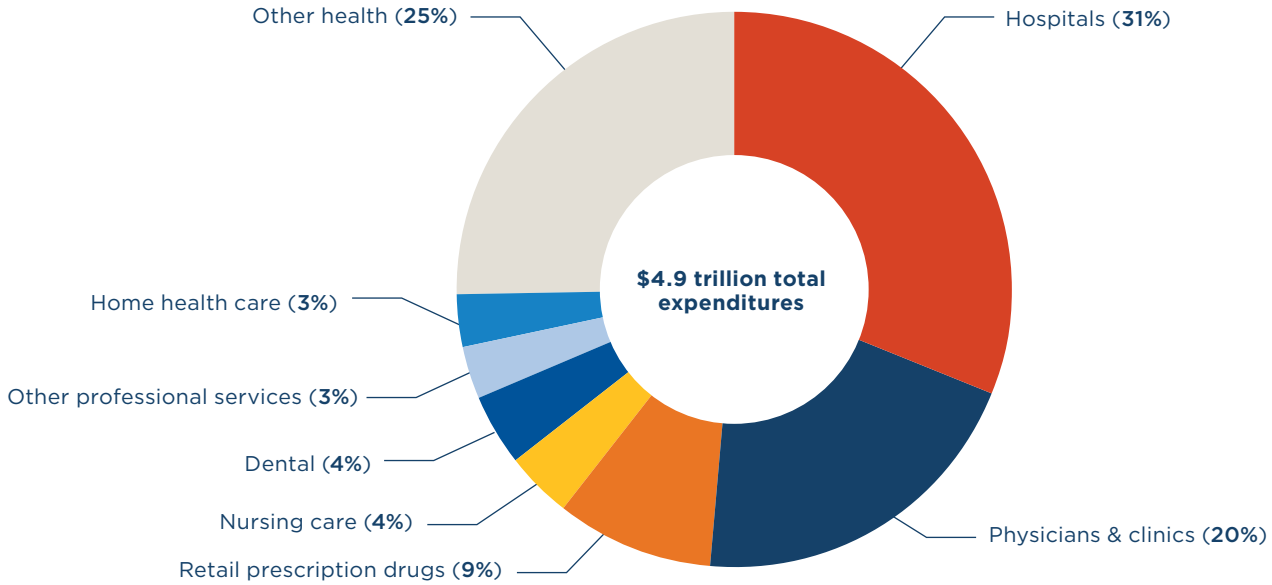
Medicare rates are deliberately set to cover the efficient cost of care, and hospitals across the country continue to participate in Medicare and Medicaid, demonstrating that these payments are financially viable. There is no data to suggest hospitals need to charge 200% or more of Medicare rates to break even, except for those heavily investing in high-end amenities to attract higher-margin commercial health plan members.

> *"Hospitals do not need a Medicare payment boost for 2027 beyond the update to be provided in the statutory formula, says the Medicare Payment Advisory Commission (MedPAC)."*
>
> — **HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION DECEMBER 15, 2025**

Research consistently shows that hospitals with greater market power charge commercial payers higher prices regardless of payer mix or Medicare or Medicaid payment levels. In fact, hospitals with the highest commercial prices often have strong margins and substantial reserves, indicating that pricing reflects negotiating clout, not necessity.

Spending on Hospital Care Totaled $1.5 trillion in 2023, Representing Nearly One Third (%31%) of National Health Expenditures in That Year

Distribution of expenditures by type of good or service, 2023



Note: Hospital spending includes expenditures on both inpatient and outpatient services. "Other health" includes spending on durable and non-durable products; residential and personal care; administration; net health insurance; and other state, private, and federal expenditures. "Other professional services" includes spending for services provided by chiropractors; optometrists; physical, occupational, and speech therapists; podiatrists; private-duty nurses; and others. "Nursing care" represents expenditures for nursing care facilities and continuing care retirement communities. Percentages do not sum to 100% due to rounding.

Source: KFF analysis of National Health Expenditure (NHE) data, 2023

KFF

What is Breakeven?

Commercial breakeven is the reimbursement rate a hospital needs to receive from commercial players to cover all of its expenses for hospital inpatient and outpatient services, without profit.

It includes revenue from all sources, commercial patient hospital costs, as well as shortfall or profit from public coverage programs, Medicare disallowed costs, and other expenses, such as hospital operations, administration, ancillary services, and non-operating expenses.

Similarly, uncompensated care does not justify high prices. Hospitals receive significant federal, state, and local funding to offset uncompensated care, including Medicaid disproportionate share hospital (DSH) payments and other subsidies. Yet, commercial prices vary dramatically across hospitals with similar levels of uncompensated care, further undermining the "hidden tax" narrative.

Fact 3 Sources: MedPAC: Medicare Payment Policy Report, June 2024; Kaiser Family Foundation: Hospital Financial Status and Payer Mix; "The Cost Shift Myth," Colorado Health Institute, March 2023; 5 Key Facts About Medicaid and Hospitals, KFF, March 2025

MYTH 4:

Hospital expenses are growing faster than inflation. Economy-wide inflation significantly increases the cost of medical supplies, equipment, and purchased services (e.g., IT, food).

FACT 4:

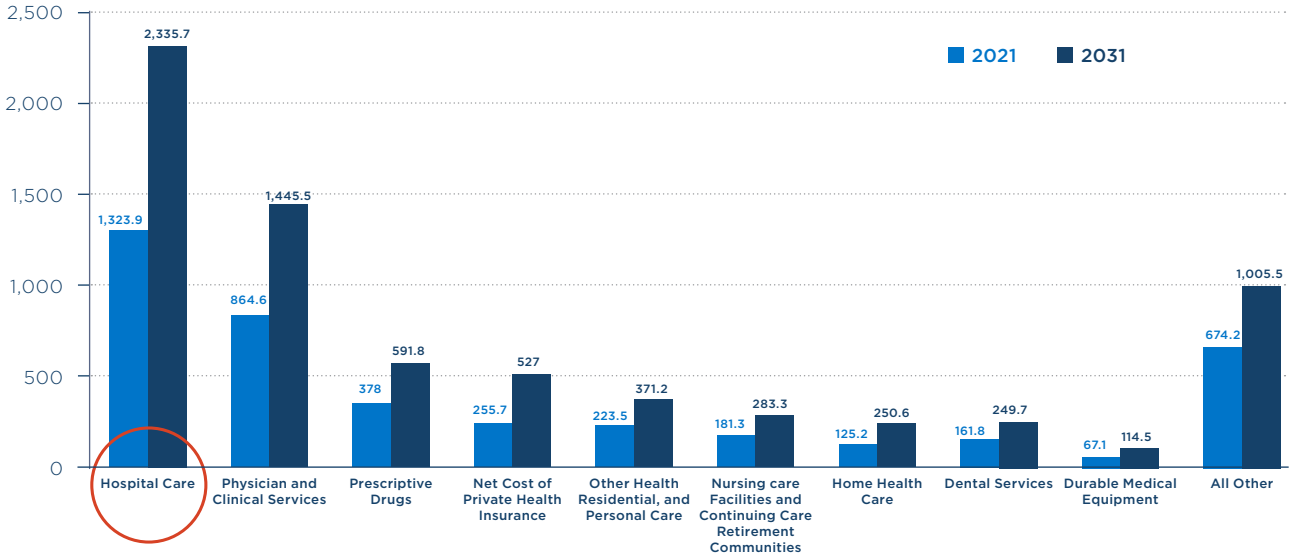
General inflation does not explain the scale or persistence of hospital price increases. While hospitals, like all businesses, experienced inflationary pressure on supplies and purchased services, hospital prices in the commercial market have risen far faster and for far longer than economy-wide inflation. Many of the steepest hospital price increases occurred before recent inflation spikes and continued even as inflation moderated.

Additionally, hospital prices vary dramatically across hospitals and regions that face similar inflationary conditions. If inflation were the primary driver, price increases would be more uniform. Instead, prices for the same products and services can differ by hundreds of percentage points within the same market.

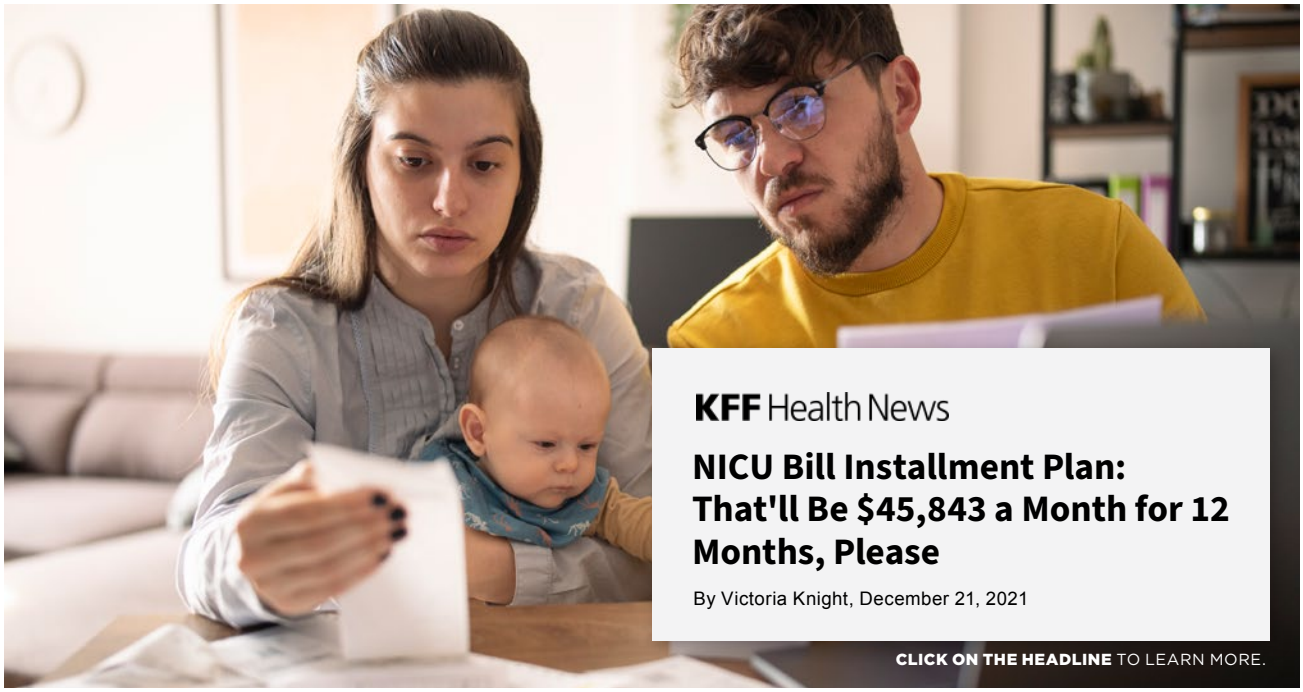
Fact 4 Sources: U.S. Bureau of Economic Analysis: Personal Health Care Price Index; Bureau of Labor Statistics Producer Price Index (Healthcare); RAND Hospital Price Growth vs. Inflation; "How Does Medical Inflation Compare to Inflation in the Rest of the Economy?" Kaiser Family Foundation, May 2024

Without Course Corrections, US Health Expenditures Projected to Hit 19.6% of GDP by 2031

Projected U.S. Healthcare Spending by Service Type: 2021–2031 ($B)



Source: Centers for Medicare and Medicaid Services Office of the Actuary, 2022-2031 National Health Expenditure Projections; Workweek Hospitalogy chart



MYTH 5:

Impact of chronic disease burden costs driven by increased utilization. Hospitals are treating more complex and chronically ill patients, which requires more intensive, and therefore costlier, care and resources.

FACT 5:

Data consistently show that hospital utilization has been flat or declining in many markets, even as prices have continued to rise sharply. The same is true for inpatient admissions and the length of stays, which do not align with the magnitude of price increases seen in the commercial market.

If rising chronic disease burden was the dominant cost driver, price growth would more closely track with changes in utilization and severity across hospitals. Instead, prices inexplicably vary for the same services, even among hospitals treating similar patient populations.

Fact 5 Sources: AHRQ HCUP Data on Utilization; MedPAC Trends in Hospital Use, 2024 Data Book, Chapter 8; KFF Health Utilization and Spending Trends

MYTH 6:

Observation and other stays are increasing in duration at lower payment rates with higher administrative burdens. MA plans rely on extended observation stays to avoid admitting patients, which helps plans reduce costs but shifts financial burden to hospitals. Admitted MA patients are also staying longer but with lower reimbursement, leaving hospitals to do more with less.

FACT 6:

Evidence from government-affiliated analyses (especially MedPAC) does not support the claim that increasing MA enrollment, on its own, significantly harms hospital finances. While hospitals report operational and reimbursement pressures linked to MA practices, the available quantitative data do not show a consistent negative impact on profit margins at a national level, although the effects may vary across hospitals, especially smaller and rural facilities.

If longer stays and lower reimbursement were materially straining hospital finances, the impact would be consistent across hospitals serving similar

"Advanced data tools help purchasing experts model and visualize trends to identify supplies that tariffs are most likely to impact. Armed with this knowledge, leaders are empowered to make more strategic purchasing decisions to reduce their organizations' dependence on high-cost supplies."

— MED CITY NEWS HOW HOSPITALS CAN BLUNT THE EFFECTS OF TARIFFS

patient populations. Instead, commercial prices vary widely—even among hospitals with comparable MA enrollment.

Hospitals voluntarily participate heavily in MA networks and negotiate these rates. If reimbursement were truly unsustainable, hospitals would limit participation or exit these arrangements. Further, administrative costs are not unique to hospitals and do not explain the magnitude or variation of commercial hospital prices.

Fact 6 Sources: MedPAC Length-of-Stay Analysis, 2024 Data Book; NIH, "Strategies to Reduce Hospital Length-of-Stay: Evidence and Challenges," May 2025; Legislation Reintroduced to Address Medicare Observation Status, Post-Acute and Long-Term Care Medical Association, June 2025; Cheating the Rules of Admission with "Observation," AMA Journal of Ethics, December 2023; Inside the Meteoric Risk of Medicare Advantage, Health Affairs, July 2024; AHRQ: Issues in Discharge Planning; JAMA Internal Medicine, Extended Hospital Stays in Medicare Advantage and Traditional Medicare, September 2025

MYTH 7:

Despite efforts to bolster the domestic supply chain, a significant proportion of essential medical goods come from international sources.

FACT 7:

While certain medical supplies and equipment are sourced internationally, spending on these goods represents a small share of total hospital operating costs and an even smaller share of the hospital services prices. Tariff-related cost impacts are episodic and limited, not systemic cost drivers.

If tariffs were a leading driver of hospital pricing, cost increases would be temporary, uniform, and closely tied to affected products. Instead, hospital prices have long varied widely across hospitals and markets regardless of supply chain exposure.

Hospitals also have tools to manage supply costs, including group purchasing organizations (GPOs), long-term contracts, stockpiling, and substitution strategies. Another recommendation is for hospitals to work with policymakers to secure tariff exemptions for vital medications and essential healthcare devices and supplies.

Fact 7 Sources: "How Hospitals can Blunt the Effects of Tariffs," MedCity News, November 2025; "How Tariffs Affect the Healthcare Industry: An Overview," EFSI, June 2025; "The Tariffs-Driven Trade War and its Implications for Healthcare," Healthcare Financial Management Association, December 2025; "Healthcare Sector Braces for Supply Chain Uncertainty with Changing Tariff Policies," AAMC, May 2025; "Building Resilience into the Nation's Medical Product Supply Chains," National Academies of Sciences, Engineering, and Medicine (NASEM), 2022

MYTH 8:

Tariffs on medical imports could significantly raise costs for hospitals.

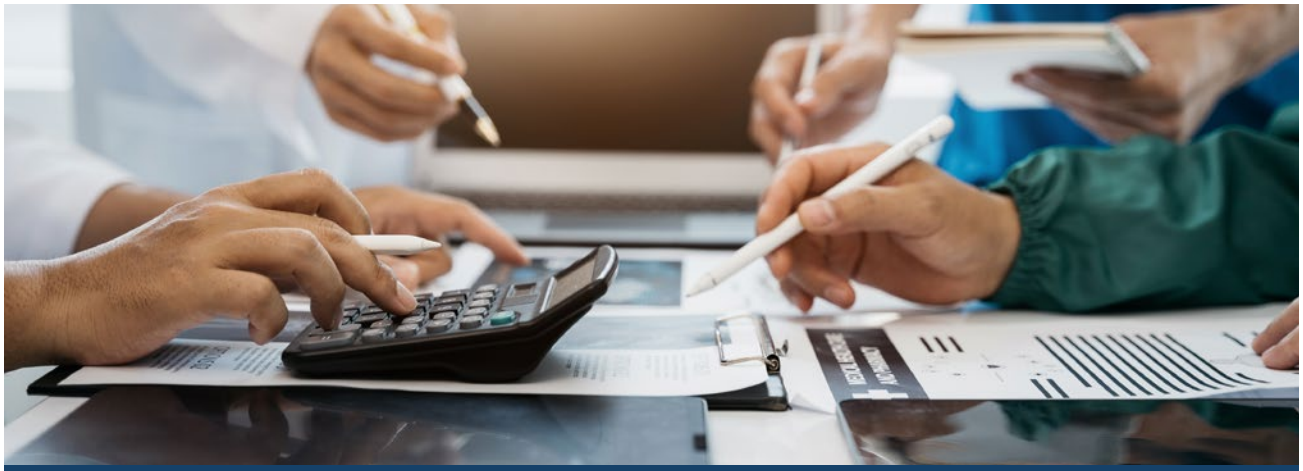
FACT 8:

Tariffs on medical imports have a time-limited impact and do not justify sustained price increases over decades. Imported medical supplies and equipment account for a relatively small portion of total hospital spending, and tariffs apply to a narrow subset of those goods. Even when tariffs affect supply costs, the impact is typically temporary and manageable.

> *"We have not made any progress [since the pandemic] in further understanding weaknesses in the supply chain."*
>
> **— ERIN FOX, PHARMD SHARED SERVICES, UNIVERSITY OF UTAH HEALTH**

If tariffs were meaningfully driving hospital costs, price increases would closely track tariff implementation and be reversed when tariffs are reduced or supply chains stabilize.

Fact 8 Sources: "How Hospitals can Blunt the Effects of Tariffs," MedCity News, November 2025; "How Tariffs Affect the Healthcare Industry: An Overview," EFSI, June 2025; "The Tariffs-Driven Trade War and its Implications for Healthcare," Healthcare Financial Management Association (HFMA), December 2025; US Tariff Industry Analysis: Pharmaceutical, Life Science, and Medical Device, PwC, March 2025



How "One Big Beautiful Bill" Affects Hospital Costs

The recently enacted "One Big Beautiful Bill" will reduce federal Medicaid spending by nearly $1 trillion over the next decade, resulting in fewer insured patients and lower Medicaid reimbursement for hospitals. The impact will be highly uneven across the hospital industry. In particular, rural and urban safety net hospitals will be most highly affected.

Large urban and multi-hospital systems, especially those with significant commercial market share, typically have strong balance sheets, diversified revenue streams, and substantial cash reserves that allow them to absorb policy changes without threatening access to care. Many of these hospitals have continued to report solid operating margins even as public reimbursement has fluctuated.

The American Hospital Association (AHA) argues that Medicaid cuts require hospitals to raise prices on employers and privately insured patients. But shifting public policy impacts onto employers and working families is neither sustainable nor appropriate. Employers have a fiduciary responsibility to spend healthcare dollars prudently on behalf of workers and their families. They cannot and should not subsidize hospital margins or offset federal policy decisions, which would interfere with their duty to pay fair prices for services provided to their own employees and families.

> ***"ERISA requires fiduciaries to discharge their duties for the EXCLUSIVE BENEFIT of the plan and participants using the skills of a prudent person in accordance with the plan's documents."***
>
> **— FROM THE NATIONAL ALLIANCE EMPLOYER PURCHASER GUIDE,** "BEYOND HOSPITAL TRANSPARENCY: GETTING TO FAIR PRICE."

Addressing the consequences of Medicaid reductions is a matter for Congress, the Centers for Medicare and Medicaid Services (CMS), and the hospital industry to resolve together. Employers, along with employees and their family members, should not be asked to absorb higher prices for hospital care unrelated to cost, quality, or value, especially in markets where hospitals command significant pricing power.

Sources: Congressional Budget Office, Budgetary Effects of Major Health Provisions; Kaiser Family Foundation, Implications of Medicaid Funding Reductions; MedPAC, Hospital Payment Adequacy and Financial Performance (2024-2025 Reports); U.S. Department of Labor (ERISA), Fiduciary Responsibilities for Employer-Sponsored Health Plans.

Coalition Member Innovations and Actions

Employers' Forum of Indiana

The Employers' Forum of Indiana (EFI) commissioned RAND Corporation in 2016 to conduct the first publicly available employer price transparency study in the US that compares what employers pay as a percentage of what Medicare pays for the same service. The resulting Employer Price Transparency Studies have led to several subsequent studies.

Millions of employers' hospital and ambulatory surgical center (ASC) insurance claims data from across the county, which note the ACTUAL price paid by employers and their employees, have been analyzed. The real price of healthcare is notoriously opaque in the US, and this project has allowed everyone to see behind the curtain for the first time.

To showcase the RAND Hospital Price Transparency Study findings, EFI built Sage Transparency. Sage Transparency is a free, public-facing tool designed to offer a clear, unbiased view of hospital price, cost, and quality data, as well as price data for ASCs and physician-administered medications. It aids employers, policymakers, researchers, and the public in making informed, evidence-based decisions. (*Click on the image below to learn more.*)

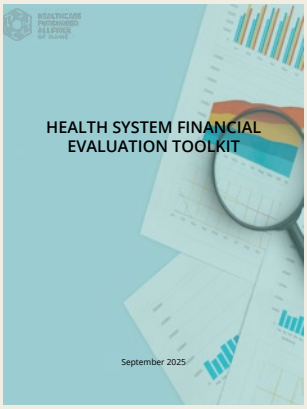
Florida Alliance for Healthcare Value

The Florida Alliance facilitates employer-led collaboration, including encouraging and assisting employers in submitting claims data to RAND's employer-led Hospital Price Transparency Study. This nationally recognized study reveals how much employers pay hospitals relative to Medicare benchmarks. In the RAND 4.0 analysis, Florida employers were shown to pay an average of **345%** of Medicare for hospital services—among the highest in the country. These findings help explain Florida's unusually high hospital spending and equip employers

with credible, actionable data they can use to negotiate more reasonable and sustainable prices for care. (*Click on the image above to learn more.*)

Healthcare Purchaser Alliance of Maine (HPA)

Premiums for employer-sponsored coverage increased by over 50% from 2014 to 2024, leaving Maine with the 11th highest premiums in the nation. As members seek strategies to moderate cost increases, one area of focus has been hospital services. A 2025 report, toolkit, and workbook examine how to balance cost containment while sustaining access to critical services by having a clear understanding of system finances. These tools can help other purchasers replicate HPA's work in their own markets. (*Click on the images to the right to learn more.*)



THESE TOOLS, ALONG WITH A CUSTOMIZABLE WORKBOOK, ARE AVAILABLE ON THE NATIONAL ALLIANCE WEBSITE.

PBGH Health Care Data Transparency Initiative

This Initiative offered employers and public purchasers unprecedented insight into the real cost and value of commercial healthcare. Launched in beta in 2025 with funding from the Peterson Center on Healthcare, the Initiative integrates transparency in coverage and hospital price transparency data with purchaser claims, quality, and safety measures. The analysis frequently reveals significant and often unjustified variation in hospital prices, with identical services varying by more than 100% across—and even within—markets, often without any relationship to quality or safety.

Hospital price data is frequently incomplete or unusable, obscuring excess pricing and limiting accountability. By connecting fragmented data sources, PBGH's Transparency Initiative delivers first of its kind

benchmarks and equips purchasers with actionable strategies to improve affordability, strengthen accountability, and support long term fiduciary governance. **PBGH now offers these services to all large employers.**

(*Click on the image above to learn more.*)

Rhode Island Business Group on Health

The Rhode Island Business Group on Health (RIBGH) is an employer-led nonprofit that represents the voice of businesses in Rhode Island on healthcare affordability, value, and transparency. RIBGH has focused critical attention on the issue of hospitals' rising overhead costs and lack of efficiency as a leading driver of unnecessarily high prices. (*Click on the image to the right to learn more.*)

Texas Employers for Affordable Health Care

Texas Employers for Affordable Health Care (TXEAHC) translated frustration with high hospital prices into meaningful state policy action. Formed by a coalition of more than 100 employers and business groups, TXEAHC set out to address the fact that hospital prices in Texas were among the highest in the country, often more than double what Medicare pays for the same services. These costs flowed directly into higher premiums for workers and higher expenses for employers.

Rather than relying on anecdotes, TXEAHC focused on data and transparency. Using publicly available hospital pricing information and employer claims experience, the coalition documented wide price variation and practices. TXEAHC made this information accessible to lawmakers through briefings, dashboards, and testimony that framed hospital prices as an economic competitiveness issue for the state

During recent legislative sessions, Texas lawmakers advanced and passed strong hospital-focused reforms, including measures to improve billing clarity, strengthen price transparency requirements, prohibit anti-competitive language in contracts between hospitals and health plans, and fund a statewide all-payer claims database. Several bills addressing hospital pricing practices moved with broad bipartisan support. (*Click on the image below to learn more.*)

CLICK ON THE HEADLINE TO LEARN MORE.

Reaching a Fair Price

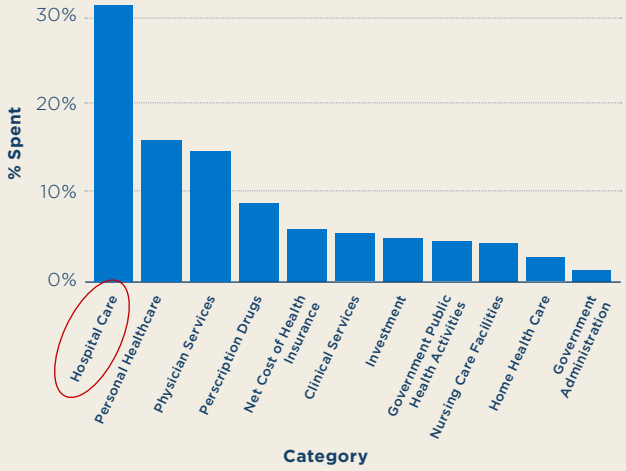
The process is to ***work together*** with employers, brokers or consultants, health plans, and hospitals to reach a "fair price" for healthcare at hospitals located in North Texas. The goal is to get hospital prices closer to 140%–200% of what Medicare pays for the exact same products, procedures, and services at the exact same facilities.

How High Hospital Costs Undermine Health Equity

High and rising hospital prices disproportionately harm lower-income workers and communities of color, worsening existing health inequities. When hospitals charge excessive prices, those costs are passed on through higher premiums, deductibles, and cost sharing, making care less affordable for the populations most likely to delay or forego treatment.

For working families living paycheck-to-paycheck, even modest increases in out-of-pocket costs can mean skipping preventive care, rationing medications, or postponing necessary procedures. Research consistently shows that medical debt is more prevalent among Black and Hispanic households, driven in part by high hospital charges that are unrelated to quality or outcomes. These financial barriers compound underlying disparities in chronic disease and access to care.

Where Does US Healthcare Spending Go?

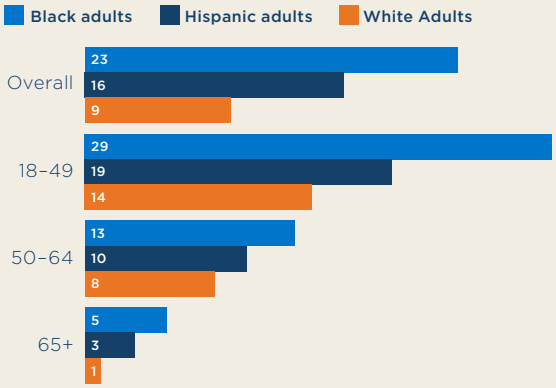


Source: American Medical Association, 2023.

Black Adults Most Likely to Report Borrowing Money to Pay for Healthcare

In the last 12 months, have you borrowed money to pay for care that you or a member of your household needed?

% Yes



Source: West Health-Gallup, Nov. 11–18, 2024.

High hospital prices also limit employer ability to invest in wages, benefits, and inclusive workforce strategies, further exacerbating economic inequities. When healthcare consumes a growing share of total compensation, workers with the least financial flexibility feel the impact most acutely.

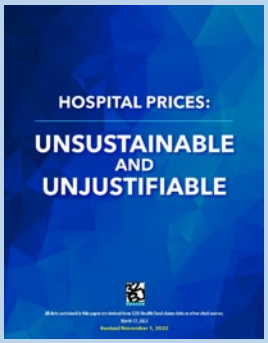
Advancing health equity requires more than expanding coverage—it requires fair and transparent hospital pricing. Excessive prices that bear no relationship to cost or value deepen inequities and undermine the affordability of care for millions of workers and their families.

CASE STUDY

How One Labor Union Achieved Over $200 Million In Savings In Four Years

The 32BJ Health Fund provides health coverage for 200,000 union members and their families in the Northeast. Members work mainly in the building trades, consisting of security workers, porters, janitors, and airport workers.

By using claims data to inform and implement plan design changes about price, quality, and access (e.g., centers of excellence, tiered networks, direct contracting…) the union has saved over $200 million in the past four years.



Click on the images to view the video and read the publications

Savings have allowed 32BJ to boost member wages by the largest amount in its history and to give each worker a $3,000 bonus while keeping employer premiums low.

Runaway healthcare costs are consistently threatening the financial sustainability of employers. Until recently, there has not been a good way to look at claims data and trends — many employers/purchasers still must fight for access to their claims data. The 32BJ Health Fund is one plan that has been fortunate to have access to its claims data for over a decade.

It was with this claims data that the Fund team was able to take concrete actions to drive down costs on behalf of workers. For example, they used claims data to look at prices for the same care at different hospitals. During this analysis, they determined that New York-Presbyterian Hospital was charging **358%** more than Medicare rates for the same care. In one example C-sections ranged from **$17,000 to $55,000**, depending on the hospital, which was significantly higher than competing hospitals. The wide variation of price led the union to remove New York-Presbyterian from its network in 2022, delivering significant savings to members and their families.

The union created other initiatives to cut its healthcare costs such as:

- Contracting directly with centers of excellence, which are high-quality, price-transparent surgical and medical centers.
- Contracting directly with hospital systems that focus on lowering prices without sacrificing quality.
- Replacing its pharmacy benefit manager (PBM) with a transparent alternative that shares savings from drug manufacturers.
- Sharpening its focus on preventive care.

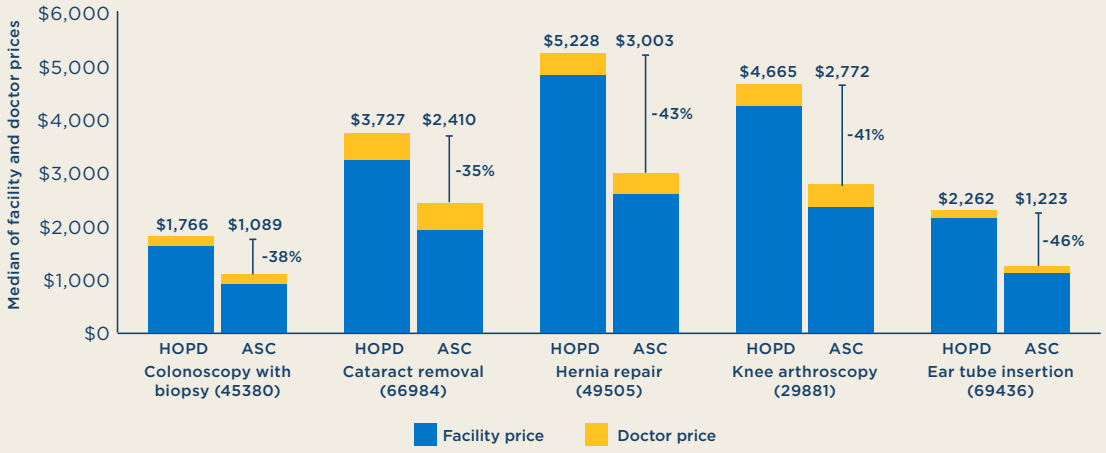
In addition to the $200 million in savings and significant pay increases associated with these changes, the union can now routinely offer access to care for its members with no copays, contributing to minimizing access and equity barriers which, in turn, improves health and health outcomes.

The Absurdity of Unchecked Prices: Same Care, Radically Different Prices

These price differences reflect where care is delivered and who has market leverage, not better care or outcomes. Employers and employees ultimately pay through higher premiums, deductibles, and suppressed wages, while hospital opacity allows routine care to be billed at premium prices.

Service	Price Variation	What's Driving the Difference
Coronary bypass without cardiac catheterization or major complications	$27,683–$247,902	Huge price differences often are present even for the same procedure at the same hospital. Using the coronary bypass example, at Tufts Medical Center in Boston, the Aetna negotiated rate is $95,989, while UnitedHealthcare's rate is $144,204. Source: Trilliant Health: Health Plan Transparency Report, 2025
Routine allergy testing	$1,827–$24,000	The higher prices are a consequence of hospitals consolidating and buying up independent practices. Allergy clinics not affiliated with hospitals have markedly lower prices. Source: PBS News, April 2025
Routine obstetrical ultrasound	$204–$469	The prices for an OB-GYN diagnostic ultrasound in the hospital outpatient department (HOPD) are more than 200% higher than those in the office setting. Between 2017 and 2022, the average service price in the HOPD increased by 7%, while the office average service price increased by only 2%. Source: Blue Health Intelligence, December 2023
Routine colonoscopy	$1,089–$1,766	Combining facility and doctor fees, the total median price for a colonoscopy at HOPDs is $1,766, but it's only $1,089 at ambulatory surgical centers (ASCs)—a 38% difference. Source: Mathematica, June 2023

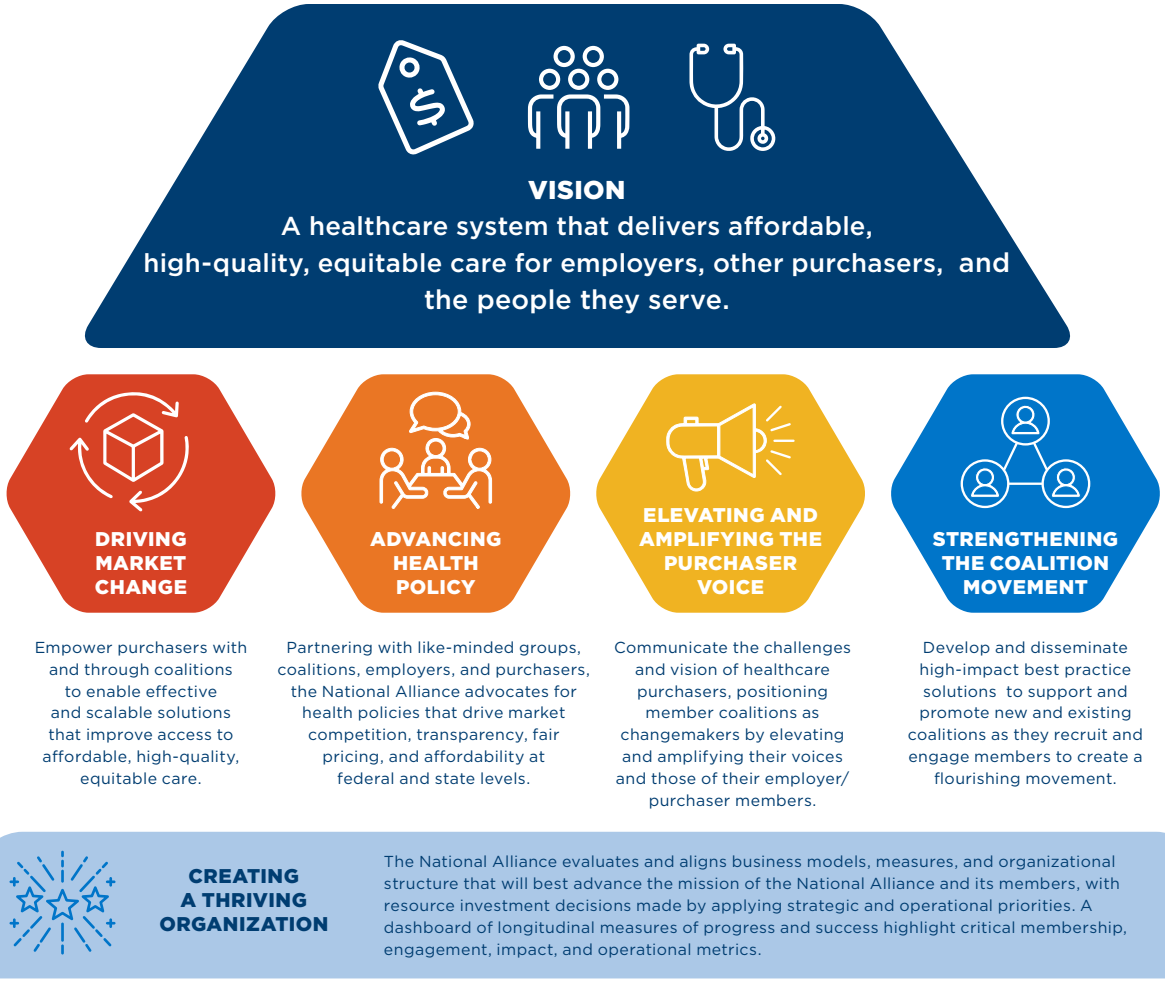
Shifting care from HOPDs to ASCs would lead to considerable savings.



Source: Mathematica's payer price analytic database.

Addendum

National Alliance Strategic Framework



> *"Patients deserve price tags. The National Alliance and its 40+ member coalitions across the country are willing to extend the hand of collaboration. Are large hospital systems and their trade associations willing to do the same?"*
>
> **— SHAWN GREMMINGER, NATIONAL ALLIANCE PRESIDENT & CEO**

Additional Reading and Resources:

National Alliance of Healthcare Purchaser Coalitions Resources

- Beyond Hospital Transparency: Getting to Fair Price
- Hospital Fair Price in Action: People Matter
- Pulse of the Purchaser Survey Findings
- Challenging Hospital Prices: A Call for Collaboration

Additional Resources

- RAND Health Care Price Transparency Initiative
- Employers Against Hospital Pricing Abuse
- We Asked 300 People About Health Care Costs. The Numbers are Shocking. (*The New York Times, January 22, 2026*)
- The Missing Piece: Why Employers Still Can't Solve the Health Care Puzzle (*Health Affairs, January 6, 2026*)
- Why Both Republicans and Democrats are Wrong About Healthcare (*The New York Times, December 16, 2025*)
- Employers Turn to Direct Contracting as Hospital Costs Continue to Rise (*Healthcare Financial Management Association, November 11, 2025*)
- How States Can Lower Hospital Prices and Make Healthcare More Affordable (*The Commonwealth Fund, April 11, 2025*)
- Key Facts About Hospitals (*KFF, February 19, 2025*)
- Rhode Island Data Show Need for Employer Action on Hospital Pricing Abuse (*Rhode Island Business Group on Health, 2024*)

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National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

For more than 30 years, the National Alliance has brought together business coalitions and their employer and purchaser members to drive high-quality healthcare that enhances patient experience, promotes health equity, and improves outcomes while lowering costs. Its members represent public and private sectors, nonprofits, and labor unions that provide health benefits to over 90 million Americans—more than half of the employer-sponsored insurance market—spending over $850 billion annually. To learn more, visit nationalalliancehealth.org and connect on LinkedIn.