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The Headache of Hospital Pricing

JARED RHOADS

Cross-subsidization inside hospitals doesn't just distort prices, it makes healthcare harder to fix.

SOME OF THE MOST PERSISTENT PROBLEMS IN AMERICAN healthcare can be traced to structural features that conceal economic realities from patients, providers, and policymakers. The tax preference for employer-sponsored insurance is one. Over-reliance on third-party payment is another. These features have dulled price sensitivity, inflated spending, and caused patients to disengage from the economic realities of the care they consume. Another such defect that deserves more attention is the extent to which we have normalized internal cross-subsidization across different services, particularly within the hospital context.

It sounds technical, but put simply, hospitals have come to depend on an internal financial arrangement in which some lines of business are reliably profitable while others are chronic money losers. For example, elective, specialized, and outpatient-oriented services such as orthopedics, cardiology, and imaging often generate substantial margins. By contrast, emergency care, psychiatric services, obstetrics, and pediatrics are often financially weak or negative. This arrangement is causing problems, especially for anyone trying to introduce competition, transparency, or lower prices into healthcare.

This is not the same type of cross-subsidization that you might have heard about in which private payers are said to subsidize public programs by paying more for the same healthcare services than payers such as Medicare and Medicaid. That issue is important, too, but somewhat murky. In that debate, the facts are hard to pin down, and nobody has access to all the data. Talk to a C-suite hospital person, and they will assure you that cross-subsidization between private and public payers is real. Check the literature from the academic health economists, and some of them will claim that it's not.

The issue of internal cross-subsidies is different: it is about some hospital departments being used to prop up others. This situation holds back progress because once one part of the system starts to depend on hidden internal subsidies, every effort to introduce change through competition or lower prices in another high-profit area is met with outsized resistance. One service can be shown to be wildly overpriced, but the response is, "Yes, but that's what keeps the emergency department open."

How This Plays Out

Consider imaging, which is a service category that tends to be highly profitable, in part because Certificate-of-Need (CON) laws keep new competitors from moving in and bringing prices down. Free-market health policy advocates can push for repeal of CON laws, but part of what makes it possible for incumbents to push back is the argument that over at the big hospital in town, those big margins are often needed to support some other service, perhaps labor and delivery. Or take another profitable

service: orthopedic surgery. Some of those expensive surgeries could be provided at lower prices in new direct-pay (i.e., cash-only) ambulatory centers, but legislative efforts that would allow the licensing of direct-pay facilities attract pushback from incumbent hospitals that, once again, need those profits to sustain other unprofitable parts of their mission.

In American twentieth-century history, airlines and railroads both went through phases of cross-subsidization. As Dwayne Banks et al. note, "First, airlines cross-subsidized shorter-haul and lower-density traffic with profits from longer-haul, higher-density traffic. Second, railroads (at least until the creation of Amtrak in 1971) cross-subsidized money-losing passenger service with profits from freight." But these arrangements tend to be unstable over time. Once competition emerges, the cross-subsidy gets exposed and becomes harder to maintain. Incumbents need to become increasingly political in order to fend off competitors who want to break into certain market segments. This is how we get incumbents making allegations of "cream skimming."

Cross-subsidization across hospital services is not what one would normally expect to see in a free and properly functioning market. In most industries, each product or service is expected to stand largely on its own. Usually when a business continually loses money on one service or product line, it responds by raising prices, cutting costs, finding a more efficient delivery model, or shutting down that product or service altogether.

Hospitals operate differently because our public policy choices have made them operate differently. The clearest example is emergency care. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals must provide emergency care and stabilizing treatment regardless of a patient's ability to pay. Whatever one thinks of that obligation, we have never paired it with a transparent financing mechanism. Instead, it basically functions as an unfunded mandate, which forces hospitals to figure out ways to recover the money elsewhere.

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Another cause is the general reliance of hospitals on government payers that pay administered rates instead of actual market prices. Medicare's Prospective Payment System (PPS) and Medicaid's cost-plus reimbursement formulas lock hospitals into fixed rates for inpatient and emergency services, while private insurers negotiate separately for high-margin procedures. These formulas are decided on by a committee, not through a market process. As such, it is possible for public payment rates to bear little relationship to local supply, demand, or actual costs of delivering care, creating some "misses" that are high and some that are low.

Finally, as already mentioned, CON laws and other entry barriers protect incumbent hospitals from competition in many of their most profitable service lines. This helps preserve the profit pools that make internal cross-subsidization a workable kludge, but also sets up the tensions that emerge when reformers ask to expose those services to competition.

What Prices Tell Us

Prices convey important information. They tell producers where demand is strong, where efficiency gains are possible, and where resources should flow. High profits attract more suppliers, which has the effect of driving prices down in the long run. Low profits are often a signal that prices are too low; let prices rise, and more suppliers will eagerly provide that service. But in American healthcare, those signals get blurred and suppressed. If a knee replacement or MRI carries a large markup not because it is especially costly to provide, but because it is silently financing some worthy but underfunded activity elsewhere, then the posted price is not providing a useful market signal.

That is not how most sectors of the economy work. In normal businesses, each department or service is roughly sustainable on its own terms. Walmart does not run a business model in which one of its product

categories must earn extraordinary margins in order to offset permanent losses in another. It doesn't "make bank" on sporting goods and lawn and garden while losing its shirt, so to speak, on home goods and health and beauty. Profitability may vary across departments, and occasionally a department might struggle and even make a temporary loss, but rare is the business that intentionally maintains or tolerates extreme cross-subsidization across basic lines of operation. And, crucially, businesses like Walmart don't use cross-subsidization to justify getting politically involved in blocking new entrants and innovators. They just focus on competing.

Granted, hospitals face challenges and obligations that ordinary retailers do not. But we pay for those obligations dearly when we incentivize hospitals to go to great lengths to protect profitable service lines from competition. The hospital industry spends hundreds of millions of dollars on state and federal lobbying annually. A significant portion of this spending goes toward protecting highly profitable service lines, such as surgery, imaging, and oncology, from competitors like Ambulatory Surgery Centers (ASCs) and independent imaging centers. That makes all of healthcare a little less functional.

When you think about internal cross-subsidization alongside other generally recognized structural problems (e.g., the tax exclusion for employer-sponsored insurance and the overreliance on third-party payers), you can see some parallels. All three are features that impair price formation and sever the connection between value and payment. All three make healthcare less legible to ordinary people. And all three make reform harder because they create webs of dependency that defenders of the status quo can invoke whenever change is proposed. We do not need to pick which is the worst distortion. It is enough to think of all of them as things worth fixing.

Could Things Be Different?

None of this is intended to be an attack on these less profitable services as such. Emergency departments, psychiatric care, maternity wards, and other such services are all important parts of healthcare. It is possible for

a service to be important and socially valuable but commercially unviable or just hard to keep afloat. For instance, emergency departments must be available 24/7 whether or not patients are coming in for care. Maintaining readiness is expensive. But for these categories of services, instead of camouflaging the subsidy the way we currently do in healthcare, we could at least have a more open and honest conversation about whether and how to make these services viable.

Reform could begin by insisting on clearer accounting and greater transparency around service lines. Patients receiving one service shouldn't be unknowingly charged higher prices in order to finance other services, and the public should have a clearer picture of which service lines generate surpluses and which require support. To bring the highly profitable services back to a "normal" level of profit, we should repeal CON laws so that low-cost providers can enter any market where demand exists and drive prices down. As for bringing the current money-losing services into the black, greater transparency and honesty about the true cost of these services would provide justification and cover for these services to raise their prices, which might be what is needed in order to bring the system into balance. All of this happening simultaneously (i.e., price decreases for some services and price increases for other services) might mean that insurance premiums could actually stay level.

A separate reform idea is to revise the prospective payment system used by the Center for Medicare and Medicaid Services (CMS) to incorporate price signals from comparable private-payer transactions. This could enable hospitals to get paid prices that are more market-like, although it should be emphasized that annually reviewing rates and changing them by a rulemaking process is not the same as following freely fluctuating market prices. Administrative pricing cannot fully replicate a market, but it can be improved.

In summary, a better healthcare system should have more respect for prices, profits, and losses. If American healthcare is ever to become more transparent and less resistant to change, we will need to confront the hidden structures that keep it so rigid. We can't make tradeoffs disappear, but we can make them more visible, and if we've forced hospitals to take on unfunded mandates, we should be more open and honest about it so

that the public isn't left with the impression that it is getting a benefit without a cost. A first step in that direction is to recognize the tensions that cross-subsidization within hospitals presents. Then we can start approaching some reforms.

Jared Rhoads is the founder and executive director of the Center for Modern Health. He received his MPH degree from the Geisel School of Medicine at Dartmouth, and an MS degree from Bentley University. He also teaches health policy in the graduate public health program at Dartmouth, advising graduate students on their independent research projects. Before teaching, Rhoads worked in healthcare consulting in a role that handled policy and emerging practices.

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