



Rising Health Care Costs in Wisconsin: The Case for Price Transparency*

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Executive Summary

- Hospital service costs nationally have surged **260%** since 2000—nearly three times faster than Wisconsin median household income (+83%) and Midwest CPI (+77%).
- Family health insurance premiums have exploded **365%** since 1999, from \$5,809 to \$26,993. Wisconsin hospitals now charge the **fourth-highest** prices in the nation—and the **highest in the Midwest**—at **321%** of Medicare rates.
- Hospitals drive **31%** of all U.S. health spending (\$1.5 trillion of \$4.9 trillion in 2023), making their prices the single biggest barrier to affordability.
- **69%** of Wisconsin employers say rising health care costs have already forced them to cut hiring, slash investment, reduce compensation, or raise prices.
- Workers bear a crushing share: family premium contributions have jumped **338%** since 1999, while average single deductibles have more than tripled (+**233%** since 2006). Rising hospital prices act as a hidden “payroll tax on labor,” suppressing wages and jobs outside health care.
- The same procedure can cost vastly different amounts across Wisconsin hospitals. Median negotiated rates for a diagnostic colonoscopy, for example, range from around \$1,469 at Marshfield/Sanford to more than \$4,600 at Froedtert Milwaukee—yet patients and employers rarely see these prices.
- **Policy imperative:** Price transparency must be the flagship response. Mandate full federal compliance, build a state-sponsored price-comparison tool, create a mandatory all-payer claims database, and strengthen antitrust scrutiny of hospital mergers.

1 Introduction

Wisconsin's economy enters 2026 on solid footing. Unemployment remains low, labor force participation exceeds the national average, and the state's manufacturing sector continues to adapt and grow. Yet beneath this surface-level stability, a significant vulnerability has been building for more than two decades. While wages and overall prices have moved roughly in tandem, the costs of several essential goods and services have far outpaced both. Among these, health care stands out as the most consequential.

According to the U.S. Bureau of Labor Statistics (BLS) and the U.S. Census Bureau:

- Wisconsin median household income rose approximately **83 percent**, from \$45,090 in 2000 to \$82,560 in 2024 (the latest available year).
- The Midwest Consumer Price Index for All Urban Consumers (CPI-U) rose approximately **77 percent** between 2000 and 2025. The BLS does not publish a Wisconsin-specific CPI. We use the Midwest CPI when it is available, and use the national CPI otherwise.
- Medical care services costs in the Midwest rose approximately **140 percent** between 2000 and 2025.
- Hospital services costs rose approximately **260 percent** between 2000 and 2025.

Figure 1 shows that, in addition to outpacing median household income and overall CPI, the increases in the price of medical care services and hospital services are also significantly higher than those of rent, food, and shelter.

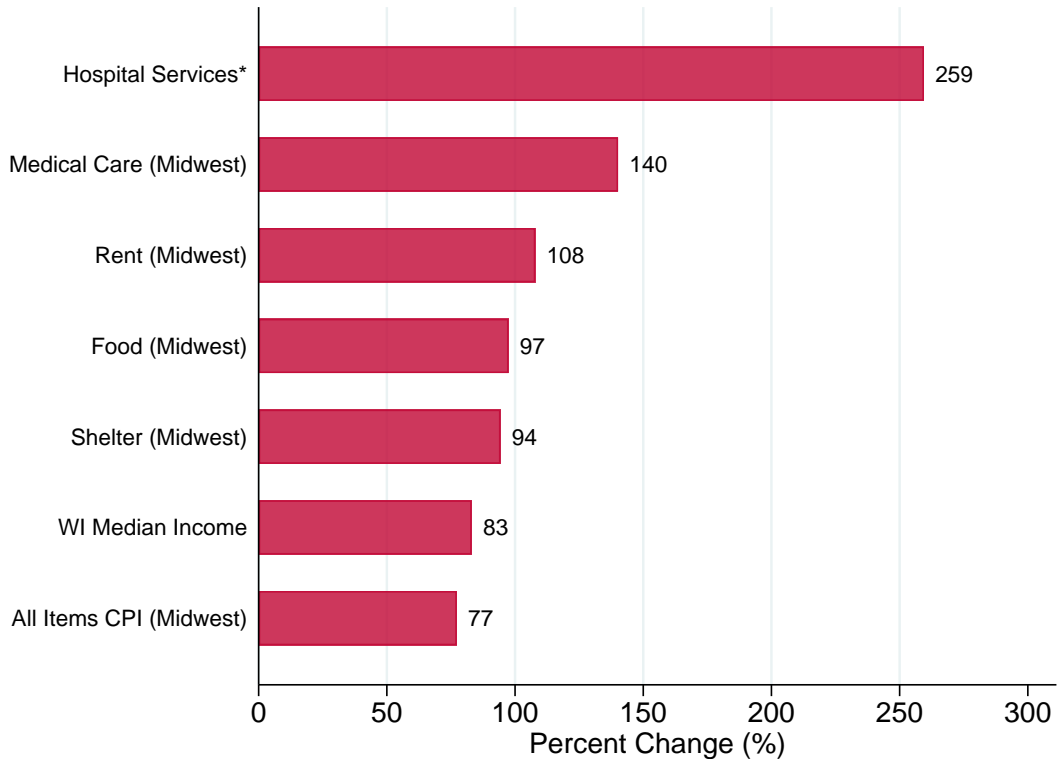


Figure 1: Cumulative Percentage Growth in Selected Costs vs. Wisconsin Median Household Income, 2000–2025.

Note: Percentage change from 2000 annual average. Hospital Services CPI is national (no Midwest series available). All other CPI series are Midwest region. Income change is 2000–2024; CPI changes are 2000–2025. *Source:* Bureau of Labor Statistics; U.S. Census Bureau. Authors’ calculations from FRED data.

This report focuses on hospital costs because hospitals are the largest single component of health care spending. In 2023, hospital care accounted for **31 percent** of all national health expenditures—\$1.5 trillion of the \$4.9 trillion total (Centers for Medicare & Medicaid Services, 2025). Understanding hospital pricing is therefore central to understanding why health care has become so expensive.

We treat the escalation of health care costs in Wisconsin as fundamentally an *economic competitiveness* issue. In an employer-sponsored insurance system, health care costs are shared between firms and their workers. When these costs rise, employers face pressure to reduce hiring, cut investment, or shift costs to employees through higher premium contributions and deductibles. Employees, in turn, experience lower take-home pay and—as recent research demonstrates—suppressed wages.

Wisconsin competes for business investment and skilled workers with other Midwestern states. We provide evidence suggesting that health care costs in Wisconsin are higher than those of its neighbors. This creates a competitive disadvantage that affects every

sector of the economy. Moreover, we show that there is extraordinary variation in health care prices across Wisconsin. Because consumers are often unaware of these price differences, they cannot direct their health care spending toward lower-cost, higher-value providers. Price transparency—making actual negotiated prices readily accessible—is a critical policy lever for introducing competitive pressure and reducing costs.

2 Incidence on Employers

For most employers, health insurance is the single largest non-wage component of total compensation. According to the Kaiser Family Foundation’s annual Employer Health Benefits Survey, the total annual premium for employer-sponsored family coverage rose from \$5,809 in 1999 to \$26,993 in 2025—an increase of **365 percent** (Kaiser Family Foundation, 2025). In a companion national analysis, Kanimian and Ho (2025) find that total family premiums rose 342 percent between 1999 and 2024, while workers’ earnings rose only 119 percent over the same period.

The KFF survey also shows that employers pay on average \$20,143 per covered family, which is 74.6 percent of the total premium. The KFF survey reports national averages. State-level data are not available from KFF for the full 1999–2025 period. Given that Wisconsin’s hospital prices exceed the national average, as shown below, the national premium figures likely *understate* the burden on Wisconsin employers.

2.1 Wisconsin Employers Report Concrete Harm

The aggregate premium data are consistent with the experience reported by Wisconsin employers. A Summer 2024 survey by the Wisconsin Manufacturers & Commerce business association found (Wisconsin Manufacturers & Commerce, 2024):

- **44 percent** of Wisconsin employers saw health care costs rise by more than 10 percent in the prior year.
- **69 percent** reported that health care costs had produced at least one negative consequence for their business: reduced hiring, lower investment in equipment or facilities, reduced employee compensation, or higher prices for their own products and services.
- **54 percent** of employers operating in multiple states reported that they pay more for health care in Wisconsin than in other states.
- Some respondents reported they had considered expanding operations outside Wisconsin, or relocating out of the state entirely, in part because of health care costs.

When asked what state policy could do to help their business, **41 percent** of Wisconsin employers answered “make health care more affordable”—the single most cited state-policy priority (Wisconsin Manufacturers & Commerce, 2025).

2.2 Why Wisconsin Prices Are So High: Hospital Market Power

A large part of the answer lies in the prices charged by the state’s hospitals. The RAND Corporation’s Hospital Price Transparency Study compares commercially negotiated hospital prices to Medicare payment rates across the country. The most recent edition finds that **Wisconsin hospitals charge an average of 321 percent of Medicare rates**—meaning that private insurers (and, by extension, Wisconsin employers and employees) pay more than three times what Medicare pays for the same services (Whaley et al., 2024). This places Wisconsin **fourth highest nationally** and **highest in the Midwest**, well above the national average of 254 percent. Figure 2 presents these comparisons.

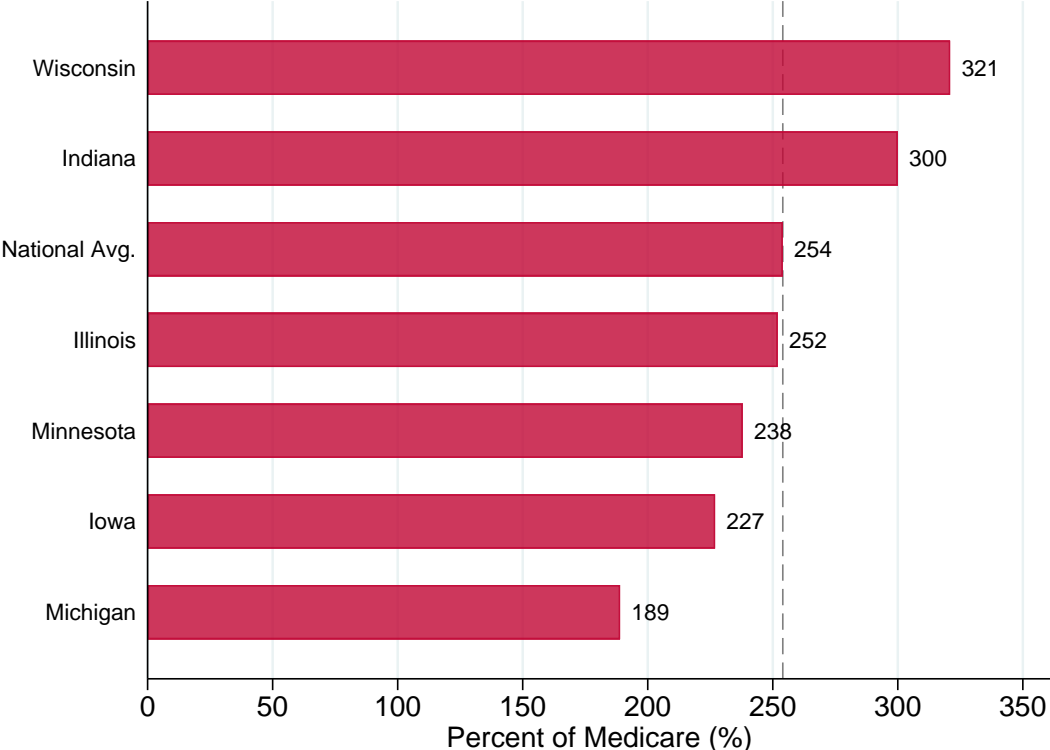


Figure 2: Hospital Prices as a Percentage of Medicare Payment Rates: Wisconsin vs. Selected States and National Average, 2022.

Note: Data reflects 2020–2022 privately insured claims. *Source:* RAND Hospital Price Transparency Study, Round 5.1 (December 2024).

Because Medicare rates are set administratively by the Centers for Medicare & Medicaid Services and are uniform across payers within a geographic area (adjusted for local input

costs), they provide a consistent benchmark for cross-state comparisons. The hospital industry has argued that Medicare pays below the cost of treating patients, forcing hospitals to charge commercial payers more to remain financially viable. There is some basis for this claim: the Medicare Payment Advisory Commission (MedPAC) reports that the overall Medicare margin for hospitals was **–13 percent** in fiscal year 2023, meaning that hospitals on average receive 87 cents in Medicare payment for every dollar of allocated cost (Medicare Payment Advisory Commission, 2025). However, MedPAC also identifies a subset of “relatively efficient” hospitals—those with lower costs and higher quality—that achieved a Medicare margin of approximately **–2 percent**, close to breakeven. This suggests that a substantial portion of the industry-wide Medicare loss reflects operational inefficiency rather than inadequate payment rates. Moreover, even granting that hospitals lose money on Medicare, the relevant question for Wisconsin competitiveness is not whether commercial prices exceed Medicare—they do everywhere—but *why they exceed Medicare by so much more in Wisconsin than in neighboring states*.

While the RAND study is the most comprehensive publicly available comparison of commercial-to-Medicare hospital prices across states, it has limitations that should be acknowledged. In most states, including Wisconsin, RAND relies on claims data contributed voluntarily by self-insured employers—a “coalition of the willing”—rather than a comprehensive claims database (Whaley et al., 2024). The Wisconsin Hospital Association (WHA) has pointed to large year-to-year fluctuations in RAND’s Wisconsin estimates as evidence that the sample may not be representative, noting that the same hospital showed ratios of 290, 185, and 338 percent of Medicare across three successive rounds (Wisconsin Hospital Association, 2024). These fluctuations likely reflect changes in which employers contribute data from round to round, not actual swings in hospital pricing. The critique underscores a real limitation: without a mandatory all-payer claims database, no study—including RAND’s—can produce fully representative estimates of commercial hospital prices in Wisconsin. We are aware of no alternative analysis that has produced a materially different picture.

Specific Wisconsin hospital systems charge even higher rates. RAND’s system-level data show that Froedtert Health charges an estimated 406 percent of Medicare—the highest among major Wisconsin systems—while Mayo Clinic Health System charges 352 percent, Bellin Health charges 326 percent, Marshfield Clinic Health System charges 319 percent, and UW Health charges 312 percent (Whaley et al., 2024).

The role of academic health centers. Wisconsin’s hospital landscape includes several major academic health centers—UW Health, Froedtert Hospital (affiliated with the Medical College of Wisconsin), and Children’s Hospital of Wisconsin—that serve as teaching hospitals, train medical residents and fellows, and maintain advanced technology and

standby capacity (Level I trauma, specialized imaging, robotic surgery) that community hospitals typically do not. These functions impose real costs. Research estimates that major teaching hospitals have costs approximately **10–20 percent higher** than comparable non-teaching hospitals after adjusting for patient complexity (Burke et al., 2021). The Balanced Budget Act of 1997 capped federal support for residency positions, creating what some have called a “teaching tax” that academic health centers must absorb through other revenue sources, including commercial insurance payments (American Hospital Association, 2022). The presence of sophisticated medical care is also a competitive *advantage* for Wisconsin in attracting employers and talent.

However, legitimate teaching and technology costs do not fully explain the pricing patterns documented above. MedPAC has found that Medicare’s indirect medical education (IME) adjustment—designed to compensate teaching hospitals for higher costs—pays at **more than double the empirically justified level**, directing over \$3.5 billion annually to teaching hospitals above what their teaching costs warrant (Medicare Payment Advisory Commission, 2021). Moreover, the variation in commercial prices across Wisconsin is not well correlated with teaching status: some of the highest commercial-to-Medicare ratios belong to systems that are not major academic centers, while UW Health’s ratio (312 percent) is below the state average. As Cooper et al. (2019) document, the dominant driver of price variation across hospitals is differences in market power and negotiating leverage, not differences in the cost of care delivery.

2.3 Hospital Consolidation and Its Economic Consequences

A growing body of research links hospital consolidation to higher prices. Brot-Goldberg et al. (2024b) examine the effects of hospital mergers on local economies. They find that mergers which substantially reduce competition raise commercial prices by approximately **5 percent**. But the effects do not stop at the hospital door. The resulting increase in employer health care costs leads to reduced employment and lower wages at *non-health-care* businesses in the affected area, amounting to roughly **203 job losses** and approximately **\$32 million in forgone wages** per anticompetitive merger.

In a companion study, Brot-Goldberg et al. (2024a) find that the Federal Trade Commission challenged only 13 of more than 1,000 hospital mergers nationwide between 2002 and 2020. In Wisconsin, a series of mergers and acquisitions over the past two decades has left large swaths of the state with limited hospital competition, giving dominant systems outsized pricing leverage. A recent example is the January 2025 merger of Marshfield Clinic Health System with South Dakota–based Sanford Health, creating a combined system of 56 hospitals and nearly 56,000 employees across seven states (Sanford Health and Marshfield Clinic Health System, 2025). While the merger may yield operational efficiencies, it also concentrates market power in central and northern Wisconsin, where

Marshfield (now the Marshfield Clinic region of Sanford Health) has long been the dominant provider.

3 Incidence on Employees

3.1 Rising Premium Contributions

Employers do not absorb the full cost of rising premiums. A substantial and growing share is passed through to workers. According to the KFF national survey, the average worker contribution to a family health insurance premium rose from \$1,563 in 1999 to \$6,850 in 2025—an increase of **338 percent** (Kaiser Family Foundation, 2025). Kanimian and Ho (2025) report a similar trajectory: worker premium contributions grew 308 percent between 1999 and 2024, compared to earnings growth of just 119 percent over the same period.

For a Wisconsin family earning the 2024 median household income of approximately \$82,560, the worker share of the family premium alone now represents roughly 8.3 percent of gross income—up from about 3.5 percent in 1999. When employer contributions are included, total health insurance premiums represent roughly 33 percent of the worker’s cash wages for a median-income family.

The growth in premiums reflects not only rising hospital prices but also the increasing cost of new medical technologies, including biologic therapies and personalized treatments such as CAR-T cell immunotherapies that can cost hundreds of thousands of dollars per patient. While these therapies represent genuine medical advances, their adoption raises premiums for all covered workers, compounding the effect of hospital market power on employer-sponsored insurance costs.

3.2 The Deductible Surge

Premium contributions, however, tell only part of the story. Over the past two decades, employers have increasingly shifted costs to employees through higher deductibles—the amount workers must pay out of pocket before insurance begins to cover expenses.

Nationally, among covered workers with a general annual deductible, the average deductible for single coverage rose from \$567 in 2006 (the first year of consistent KFF tracking) to \$1,886 in 2025—a **233 percent increase** in less than 20 years (Kaiser Family Foundation, 2025). Today, 34 percent of covered workers face a deductible of \$2,000 or more, and a significant share face deductibles of \$3,000 or higher. Figure 3 shows this trajectory.

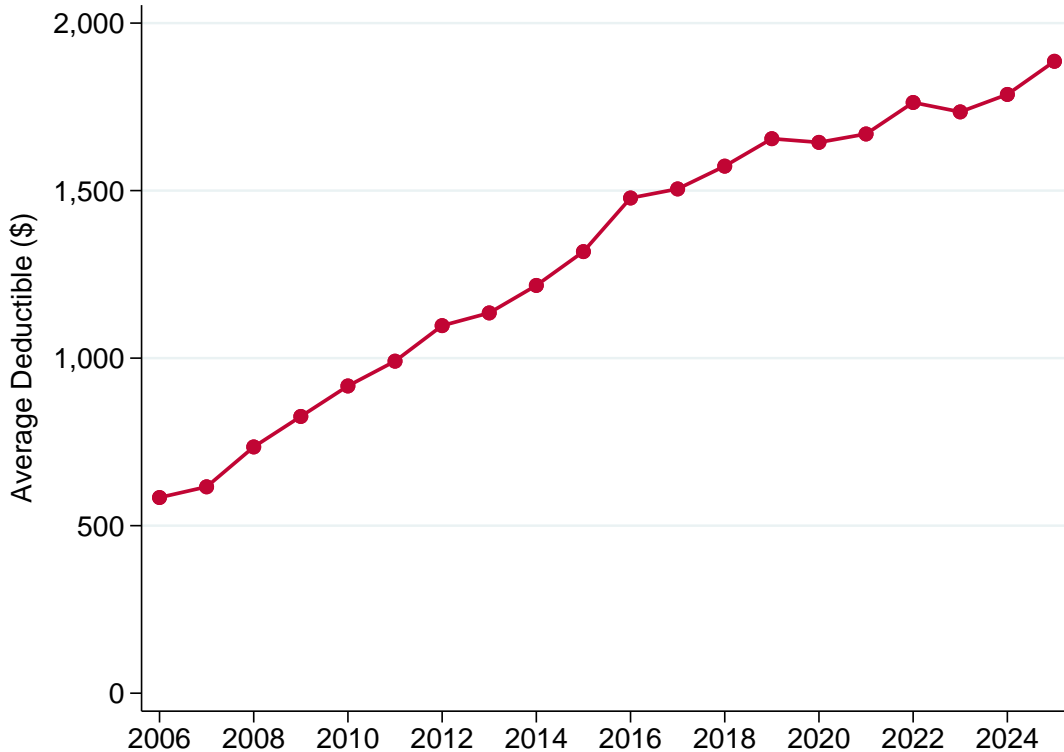


Figure 3: Average Annual Deductible for Single Coverage, 2006–2025.

Note: Among covered workers with a general annual deductible. *Source:* Kaiser Family Foundation Employer Health Benefits Survey (2006–2025).

3.3 The “Hidden Tax” on Wages

Rising health care costs also suppress wages, even for workers who never incur large medical expenses. In the framework of Brot-Goldberg et al. (2024b), rising health care prices function as a “*de facto payroll tax on labor.*” Their analysis estimates that a 1 percent increase in health care prices leads to an approximately **0.4 percent reduction** in payroll and employment at non-health-care employers. This hidden tax is regressive: the effects are concentrated on workers earning between \$20,000 and \$100,000 per year. When a Wisconsin hospital system negotiates a price increase with a commercial insurer, the consequences ripple outward through the entire local labor market.

3.4 Workers’ Compensation: A Wisconsin-Specific Burden

The burden on Wisconsin employees extends to the workers’ compensation system. Studies by the Workers Compensation Research Institute (WCRI) have consistently found that Wisconsin’s workers’ compensation medical payments are among the highest in the nation—**39 percent above the median** of study states (Workers Compensation Research Institute, 2024).

A key reason for this outlier status is that Wisconsin was, until recently, one of only six states without a medical fee schedule for workers' compensation—a standardized schedule of maximum payment rates for medical services provided to injured workers. Without such a schedule, providers could charge—and be paid—rates far exceeding those in neighboring states.

Wisconsin has recently enacted a workers' compensation medical fee schedule, a welcome development. As the fee schedule takes effect, it should help bring Wisconsin's workers' compensation medical costs more in line with those of peer states (Workers Compensation Research Institute, 2025). The experience of Virginia, which saw a **13 percent decrease** in payments per claim after implementing its fee schedule, offers a useful benchmark for what Wisconsin might expect.

4 Price Variation and the Case for Transparency

4.1 Extraordinary Price Variation Across Wisconsin

If Wisconsin's health care prices were uniformly high, the policy response might focus solely on cost containment. But the prices are not uniform. They vary enormously—across hospitals, across counties, and even across departments within the same facility.

Under the CMS Hospital Price Transparency Rule (45 CFR Part 180), effective January 1, 2021, all U.S. hospitals must publish machine-readable files containing at least four types of standard charges: (1) *gross charges* (the hospital's list price—akin to a sticker price that few patients actually pay); (2) *discounted cash prices* (the self-pay rate); (3) *payer-specific negotiated charges* (the rates actually paid by each commercial insurer); and (4) *de-identified minimum and maximum negotiated charges* (Centers for Medicare & Medicaid Services, 2021). Of these, the *payer-specific negotiated rates* are the most economically meaningful, because they reflect what insurers—and by extension employers and employees—actually pay. Gross charges, by contrast, function like a list price in a market with pervasive second-degree price discrimination: they set an upper bound but tell us little about what the typical commercially insured patient costs the system. We report gross charges below where they are the only available figure, but we emphasize negotiated rates wherever possible.

We analyze machine-readable price transparency files posted by seven Wisconsin hospitals: UW Health (Madison), Froedtert Health (Milwaukee, West Bend, Menomonee Falls, and Manitowoc), and the Marshfield Clinic region of Sanford Health (Marshfield and Eau Claire). Marshfield Clinic Health System completed its merger with South Dakota-based Sanford Health on January 2, 2025 (Sanford Health and Marshfield Clinic Health System, 2025). The transparency files analyzed here were posted under the Marshfield Clinic name; we refer to the system as “Marshfield/Sanford” for clarity. We find that:

- The gross charge for a **CT scan of the abdomen and pelvis** (CPT 74177) ranges from \$2,650 at Marshfield/Sanford’s Eau Claire campus to \$6,707 at Froedtert Hospital in Milwaukee—a ratio of **2.5 to 1**. Median negotiated rates for this procedure range from approximately \$1,459 to \$3,551, a ratio of **2.4 to 1**.
- An **MRI of the brain** (CPT 70551) has gross charges ranging from \$1,728 at Marshfield/Sanford’s Eau Claire campus to \$5,039 at Froedtert Hospital—a ratio of **2.9 to 1**. Median negotiated rates range from approximately \$1,642 to \$3,359.
- A diagnostic **colonoscopy** (CPT 45378) has a gross charge ranging from \$1,546 at Marshfield/Sanford to \$3,873 at UW Health—a ratio of **2.5 to 1**. Median negotiated rates at Froedtert system hospitals exceed \$4,200, nearly three times the Marshfield/Sanford rate of approximately \$1,469.
- A **knee arthroscopy with meniscectomy** (CPT 29881) has a median commercial negotiated rate ranging from \$6,687 at Marshfield/Sanford (Eau Claire) to \$10,054 at Froedtert Hospital—a ratio of **1.5 to 1**.

The RAND system-level data discussed in Section 2 confirm this pattern: the dominant systems charge 312–406 percent of Medicare, while other Wisconsin hospitals charge considerably less. Figure 4 illustrates the range.

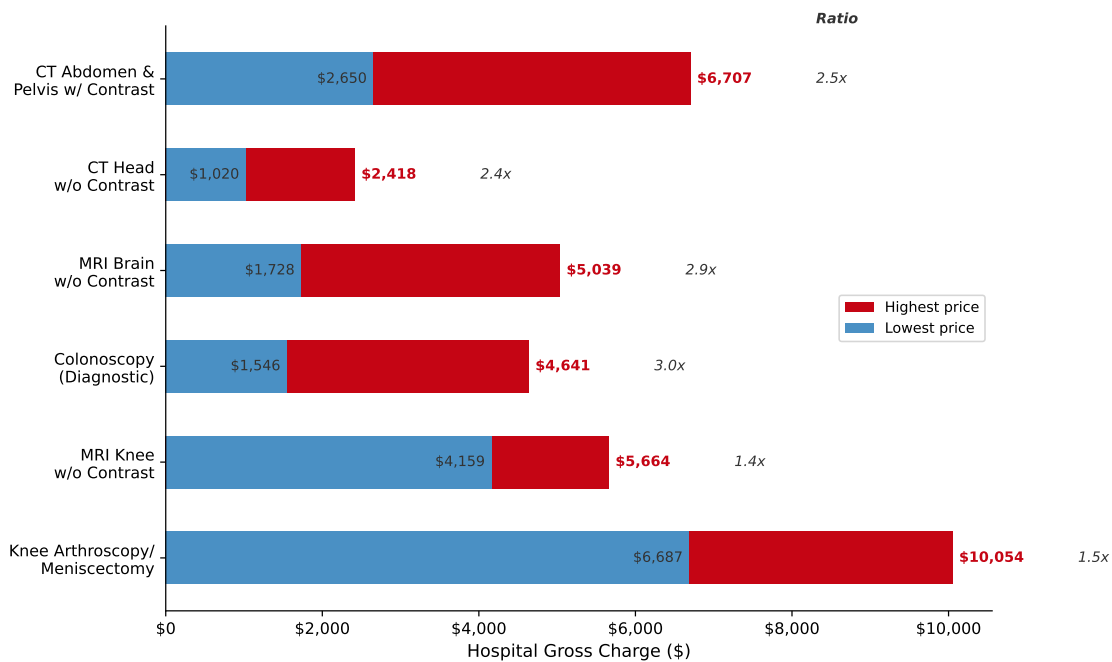


Figure 4: Price Variation for Selected Procedures Across Wisconsin Hospitals.

Source: Authors’ analysis of hospital machine-readable price transparency files downloaded in March 2026. Gross charges and median negotiated rates where available. Hospitals include UW Health, Froedtert Health (4 facilities), and Marshfield Clinic region of Sanford Health (2 facilities).

What this variation means in dollars. To illustrate the potential magnitude of savings from directing patients toward lower-priced providers: the median negotiated rate for a diagnostic colonoscopy ranges from approximately \$1,469 at Marshfield/Sanford to over \$4,600 at Froedtert Hospital—a difference of more than \$3,100 per procedure. For a CT scan of the abdomen and pelvis, the difference in median negotiated rates across hospitals in our sample exceeds \$2,000. Colonoscopies and CT scans are among the most commonly performed hospital procedures in the United States. If commercially insured patients at the highest-priced Wisconsin hospitals were instead treated at hospitals charging the lowest negotiated rates in our sample, the per-procedure savings would be substantial. Scaled across the tens of thousands of these procedures performed annually in Wisconsin, the potential aggregate savings for employers and employees would reach into the tens of millions of dollars—for these procedures alone.

This variation is not primarily explained by differences in quality. Research has consistently shown that higher-priced hospitals do not, on average, deliver better outcomes than their lower-priced counterparts (Beauvais et al., 2020; Whaley, 2018). It is true that some of the higher-priced hospitals in our sample—particularly the academic medical centers—maintain more advanced imaging equipment and surgical technology, and these investments carry real costs. But the magnitude of the price variation documented above far exceeds what differences in technology can explain. The variation instead reflects differences in market power, negotiating leverage, and—crucially—the absence of the kind of price information that would allow purchasers to direct patients toward higher-value providers (Cooper et al., 2019).

Why don't insurers use this variation? A natural question is why commercial insurers, who negotiate these rates, do not do more to steer patients toward lower-priced providers. Insurers' value proposition to employers rests partly on their negotiating power—they can obtain lower rates than any single employer could. Yet the resulting variation in negotiated prices is rarely reflected in how insurers design benefits or present choices to consumers. In most plans with percentage-based cost sharing (coinsurance), patients do have a theoretical incentive to choose lower-priced providers, but insurers do little to make these price differences visible at the point of decision. In plans with flat copayments—\$X per hospital admission regardless of the hospital's negotiated rate—patients face no price signal at all. Insurers could, for example, set the patient copayment at \$0 for the lowest-priced provider and require patients to pay the full difference between the lowest negotiated rate and the rate at any other provider. Such “reference pricing” designs have shown promising results in other settings. The persistence of benefit designs that obscure price variation is itself a barrier to competition that transparency policy should address.

4.2 Geographic Variation: Region by Region

The price variation documented above is not randomly distributed across the state. It follows a clear geographic pattern, with certain regions of Wisconsin consistently paying far more than others for the same hospital services.

By mapping major hospital systems to their dominant service regions, system-level data from Whaley et al. (2024) reveal striking regional disparities (Figure 5):

- **Milwaukee Metro:** Froedtert Health, the academic medical center system anchored at the Medical College of Wisconsin, charges an estimated **406 percent of Medicare**—the highest rate among Wisconsin systems.
- **Southwest Wisconsin:** Mayo Clinic Health System, the dominant provider in the La Crosse–Eau Claire corridor, charges an estimated **352 percent of Medicare**.
- **Northeast/Green Bay:** Bellin Health charges **326 percent of Medicare**, in a region where the November 2022 Bellin–Gundersen merger created an 11-hospital system with substantial market power across northeastern Wisconsin.
- **Central/Northern Wisconsin:** Marshfield Clinic Health System (now part of Sanford Health) charges **319 percent of Medicare**, essentially at the statewide average, in a region where Marshfield has long been the dominant provider.
- **Madison:** UW Health, the state’s flagship academic medical center, charges **312 percent of Medicare**—below the statewide average but still well above the national average of 254 percent.

Every one of these regional figures exceeds the national average of 254 percent, and three of the five exceed Wisconsin’s own statewide average of 321 percent (per Round 5.1 data); even UW Health, the lowest at 312 percent, is well above the national average. The systems that dominate their regional markets charge the highest prices—a pattern consistent with the market-power explanation documented by Cooper et al. (2019) and Brot-Goldberg et al. (2024*b*).

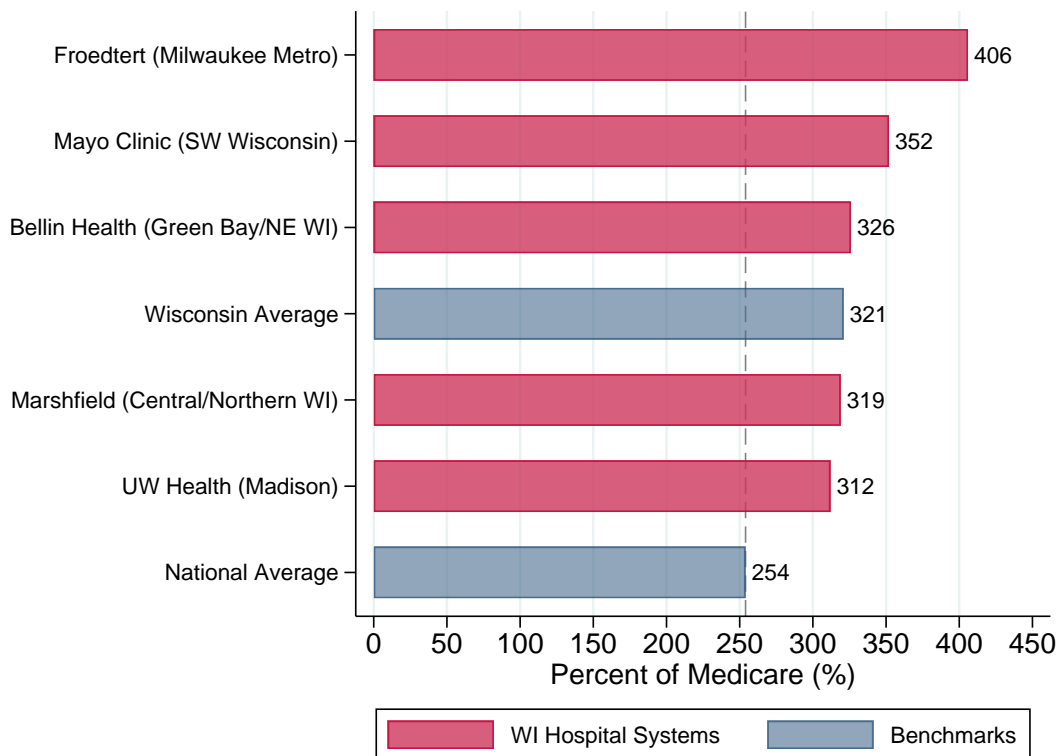


Figure 5: Hospital Prices as a Percentage of Medicare Payment Rates by Wisconsin Region.

Source: RAND Hospital Price Transparency Study, Round 5.1 (December 2024; 2020–2022 claims). Systems mapped to their dominant service regions by the authors.

Regional insurance premium variation. The geographic pattern extends beyond hospital prices to the premiums that employers and individuals pay for coverage. According to rate filings with the Wisconsin Office of the Commissioner of Insurance, the individual market exhibits large regional disparities: the same benchmark plan can cost as much as **72 percent more** in higher-cost rating areas such as Eau Claire (approximately \$706 per month) compared to Madison (approximately \$409 per month) (Wisconsin Office of the Commissioner of Insurance, 2024). In the large group market, annual premiums in the highest-cost areas (e.g., Oshkosh–Green Bay) can exceed those in the lowest-cost areas (e.g., Madison–Dane County) by roughly \$1,786 per employee.

These premium differences directly reflect the underlying variation in provider prices. In regions where a single hospital system dominates, insurers have limited leverage to negotiate lower rates, and those higher negotiated prices flow through to premiums paid by employers and workers.

Rural market concentration and the risk of hospital closures. The geographic pattern is most acute in rural Wisconsin. Williams et al. (2020) found that Wisconsin had 19

rural hospital mergers between 2005 and 2016, the third-highest count among all states. Many rural communities are now served by a single hospital system, giving that system monopoly pricing power.

At the same time, it is important to recognize that many rural and safety-net hospitals are financially fragile. The regions with the lowest hospital prices are often the same regions where hospitals are struggling to remain open and where access to care is most limited. Policy interventions aimed at reducing prices in high-cost markets must be designed carefully to avoid unintended consequences—such as further destabilizing hospitals in low-cost rural markets that are already operating on thin margins. Transparency and competitive pressure should be directed at markets where dominant systems exercise pricing power, not at vulnerable rural providers.

4.3 The State of Price Transparency in Wisconsin

Wisconsin has a longer history with health care price transparency than most states. The Wisconsin Hospital Association's PricePoint tool has been operational since 2005, making it one of the first such tools in the nation (WHA Information Center, 2024). However, PricePoint reports *charges*—the list prices that hospitals set—rather than the *negotiated rates* that insurers actually pay, limiting its usefulness for consumers.

The federal Hospital Price Transparency Rule, effective January 1, 2021, requires all hospitals to post machine-readable files containing their standard charges, including payer-specific negotiated rates (Centers for Medicare & Medicaid Services, 2021). Compliance, however, has been poor: estimates suggest that only **30–40 percent** of Wisconsin hospitals are in full compliance (Urban Milwaukee, 2024). The federal government has increased penalties—from a maximum of \$109,500 per year to as much as \$2 million for large hospitals—but enforcement has been slow and uneven.

4.4 Evidence That Transparency Works

The evidence that price transparency reduces costs, while still developing, is encouraging. Brown (2019) finds that New Hampshire's HealthCost website—one of the first state-run price transparency tools—led to an **11 percent decline in patient out-of-pocket costs** for medical imaging by the fifth year after its introduction, with the largest price decreases in the most concentrated markets. Whaley (2019) finds that private price transparency tools are associated with a **1–4 percent decrease in prices** for homogeneous services such as laboratory tests. These are modest effects in contexts of limited transparency; with broader disclosure, the effects could be substantially larger.

Only a handful of states have built effective consumer-facing tools. A grading exercise by the Catalyst for Payment Reform gave only three states—New Hampshire, Colorado, and

Maine—an “A” grade; forty-three states received an “F” (Catalyst for Payment Reform and Health Care Incentives Improvement Institute, 2016). Colorado’s approach is particularly instructive: the state built the first tool that integrates federal machine-readable hospital data into a consumer-friendly interface with personalized out-of-pocket cost estimates (Colorado Department of Health Care Policy and Financing, 2024). Wisconsin, despite its early leadership with PricePoint, has not kept pace.

4.5 Transparency Is Necessary but Not Sufficient

While we argue that price transparency is a critical first step, it is important to acknowledge that data disclosure alone does not guarantee better outcomes. As Cope (2026) argues, true consumer empowerment requires not only *access* to price data but also *interpretability* and *agency*—the ability to understand the information and act on it. The federal Transparency in Coverage rule, for instance, generated machine-readable files that are largely unusable by ordinary consumers: they contain negotiated rates for services that providers may not even offer, lack bundled pricing that would allow apples-to-apples comparisons, and present information without the clinical context needed to evaluate trade-offs between cost and quality. Research on consumer decision-making suggests that excessive, uncontextualized information can produce cognitive overload and decision paralysis rather than informed choice.

These concerns reinforce rather than undermine the case for transparency. They underscore the importance of *how* price information is presented. Simply posting machine-readable files—the current federal minimum—is insufficient. Effective transparency requires consumer-friendly tools that translate raw price data into personalized, actionable estimates of out-of-pocket costs, integrated at the point of care decisions. It also requires complementary policies that expand patients’ ability to act on price differences: broader provider networks, telehealth options that increase geographic choice, and bundled pricing that makes comparisons meaningful. Wisconsin’s policy agenda should therefore aim not merely at disclosure, but at building the infrastructure—digital tools, standardized quality labels, and network flexibility—that converts transparency into genuine competitive pressure.

5 Policy Implications and Conclusion

The evidence presented in this report points to a clear diagnosis: Wisconsin’s health care costs have risen far faster than incomes, the burden falls on both employers and employees, and the state’s hospital prices—driven by market power and consolidation rather than superior quality—are among the highest in the nation. These are economic competitiveness issues, not merely personal ones. They affect hiring, investment, wages, and the state’s ability to attract and retain businesses and workers. The burden falls

disproportionately on rural communities, where hospital markets are most concentrated and household incomes tend to be lower. Rising health care costs also strain Wisconsin's public finances through the Medicaid program (BadgerCare Plus and related programs, covering approximately 1.1 million residents) and an outlier-level workers' compensation system.

It is worth noting that hospital prices, while the focus of this report, are not the only driver of rising health care costs. The pharmaceutical industry—particularly the rapid adoption of high-cost biologic and specialty therapies—contributes significantly to premium growth. Health systems in Wisconsin operate on relatively thin margins even as they face rising input costs; the pharmaceutical sector, by contrast, has historically maintained substantially higher profit margins. A comprehensive approach to health care affordability would address pharmaceutical pricing alongside hospital pricing, but the policy levers differ and are largely federal in nature. The hospital pricing interventions discussed below are areas where state policy can make a meaningful difference.

The most promising state-level policy response is price transparency. As documented above, the evidence shows that when price information is made available, costs fall and purchasing shifts toward lower-priced providers—effects that are strongest in the most concentrated markets. The federal Hospital Price Transparency Rule has created a foundation, but poor compliance and weak enforcement have limited its impact. Wisconsin has seen recent legislative interest in addressing this gap: Senate Bill 383 in the 2025–2026 session proposed codifying the federal rule into state law with meaningful enforcement, but was not brought to a floor vote (Bradley et al., 2025). States such as Colorado, which prohibits noncompliant hospitals from pursuing patient debt collection (Colorado General Assembly, 2022) and designates transparency violations as deceptive trade practices (Colorado General Assembly, 2023), offer models for effective state-level enforcement.

Wisconsin currently lacks a mandatory all-payer claims database (APCD). The Wisconsin Health Information Organization (WHIO) operates a voluntary claims database that collects data from participating payers, but its voluntary nature means that coverage, while substantial, is incomplete and may fluctuate as payers enter or leave (Wisconsin Health Information Organization, 2024). By contrast, neighboring Minnesota operates a mandatory APCD that covers approximately 90 percent of insured residents, enabling comprehensive analyses of price variation, utilization, and cost trends (Minnesota Department of Health, 2024). A mandatory APCD in Wisconsin would serve multiple purposes: it would provide the data foundation for a consumer-facing price comparison tool, enable researchers and policymakers to identify outlier prices and monitor the effects of consolidation, and—critically—resolve the data-quality concerns that have allowed hospital associations to dismiss studies like RAND's as unrepresentative. Establishing a mandatory APCD should be a legislative priority.

Wisconsin has the institutional foundation to lead on transparency—its PricePoint tool was among the first in the nation—but the tool reports charges rather than negotiated rates. Upgrading to a consumer-friendly tool that integrates actual negotiated prices, establishing a mandatory all-payer claims database, strengthening antitrust scrutiny of hospital mergers, and implementing the recently enacted workers’ compensation fee schedule effectively would bring Wisconsin in line with the leading states. These are market-oriented policy directions that do not require price controls or government-administered rate-setting. They require only that the conditions for effective competition be established: that buyers know the price of what they are purchasing before they agree to pay for it.

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