VIEWPOINT

HEALTH POLICY

# The Commercial Differential for Hospital Prices
## Responses From States and Employers

**Christopher F. Koller, MPPM, MAR**
Milbank Memorial Fund, New York, New York; and School of Public Health, Brown University, Providence, Rhode Island.

**Dhruv Khullar, MD, MPP**
Department of Healthcare Policy & Research, Weill Cornell Medicine, New York, New York; and Department of Medicine, Weill Cornell Medicine, New York, New York.

**Corresponding Author:** Christopher F. Koller, MPPM, MAR, Milbank Memorial Fund, 645 Madison Ave, Ste 15, New York, NY 10022 (ckoller@milbank.org).

**The prices paid** for hospital services have long had a strange dichotomy. For the 37% of the population insured by Medicare or Medicaid, prices are publicly available and generally increase slowly. By contrast, prices for the commercially insured population are privately negotiated, proprietary, and confidential. These rates are closely guarded by health plans, who are convinced that negotiating with clinicians and health care organizations on behalf of consumers is a source of competitive differentiation.

However, the black box of commercial insurer prices is slowly being pried open. Aggregated claims data have allowed for a deeper understanding of the size and variation in payments to hospitals, in particular, which represent the largest component of overall health care costs at approximately 40%. Commercial hospital prices are high relative to Medicare and vary considerably both within and between markets. These price discrepancies are larger than for physician services, are increasing over time, and are responsible for a substantial proportion of overall commercial insurance premium growth. Current commercial contracting models and antitrust authorities have not been effective in curtailing this trend, and state officials and public employers are responding with greater oversight.

Medicare prices are an important reference for evaluating the effectiveness of commercial payer negotiations with hospitals. Medicare sets consistent prices nationally, adjusting them to account for regional differences in the costs of living and the training and research functions of hospitals. Employers appear to pay hospitals twice as much as Medicare for inpatient services and 3 times as much for outpatient services (**Table**). Yet, these averages mask significant variation: different hospitals in the same market command very different prices for the same services.

Hospitals have traditionally justified these differential prices by citing the need to cross-subsidize care for uninsured patients and patients enrolled in lower-paying public programs. Commercial insurers maintain that they have to pay more because the government does not pay enough. A growing body of research raises questions about whether Medicare payments are actually insufficient for financially efficient hospitals to provide high-quality care. In addition, lower rates of uninsured individuals resulting from Medicaid coverage expansion under the Affordable Care Act reduced the amount of uncompensated care provided by hospitals.

Rather, high commercial prices appear attributable in part to the relative size and market power of hospitals. When it comes to negotiation, size matters—larger hospitals command higher prices, and hospital costs appear to rise to the level of revenue negotiable rather than to quality of care. The negotiating leverage enjoyed by consolidated hospitals stands in contrast to the much smaller differential available to most physicians. A 2018 study of physician payments from the Congressional Budget Office documented commercial-to-Medicare payment ratios of 110% for office visits, 130% for cataract surgeries, and 180% for knee replacements and colonoscopies, which were substantially lower than commercial-to-Medicare payment ratios for hospital services.[8]

The prices paid by commercial insurers to hospitals have driven growth in overall health care costs, as utilization rates have remained flat and, in some cases, declined. Between 2007 and 2014, commercial insurance prices for inpatient services increased 42% and prices paid for hospital-based outpatient care increased 25%, both of which were far greater than general inflation or the increase in Medicare or Medicaid prices during the same period.[2] More recent studies from White et al[4] and the Colorado Department of Health Care Policy and Financing[7] suggest this trend is continuing. Money spent by employers on health benefits for acute health care services is money not available for prevention, employee wage increases, or business expansion.

The commercial differential for hospital prices is less of an issue in Maryland. Unlike other states, Maryland did not disband its hospital rate-setting mechanism amid the deregulation that occurred in the 1980s and persisted with a process by which public and private insurers pay the same price for hospital services. Average commercial health insurance premiums in Maryland are the lowest in the Northeast.[9] In 2014, under a revised agreement with Medicare, hospitals in Maryland converted to a global budget model, taking responsibility for both price and utilization. Starting in 2019, the model expanded to include payments to non–hospital-based clinicians in the global budget agreement with Medicare.[10]

As awareness has increased regarding the role of commercial hospital prices in driving health care growth, other states have started to take action. The Rhode Island Office of the Health Insurance Commissioner and the Massachusetts Attorney General both used their investigatory authority to document large variations in case-mix–adjusted prices paid by insurers to hospitals within the same markets, with larger hospital systems consistently commanding higher prices. Having documented these differences, Rhode Island used its regulatory authority to limit further increases in hospital prices to the Consumer Price Index, leading to a significant reduction in insurance premium growth rates.

Table. Studies Documenting Commercial Insurer Payments to Hospitals Relative to Medicare

| Source | Study Scope | Inpatient Prices, % of Medicare | Outpatient Prices, % of Medicare | Relative Price Variation, % |
|---|---|---|---|---|
| White and Whaley,[1] 2019 | 25 States (2015-2017) | 204 | 293 | 200 Between the highest and lowest state |
| Cooper et al,[2] 2018 | National (2007-2011) | 220 | NA | 229 Between the 10th and 90th percentiles for knee replacement |
| Maeda and Nelson,[3] 2017 | National (2013) | 189 | NA | 380 Between the 10th and 90th percentiles |
| White,[4] 2017 | Indiana (2013-2016) | 217 | 359 | 384 Between the highest and lowest hospital for inpatient; 290 for outpatient |
| White et al,[5] 2013 | 13 Markets | 125-350 | NA | 280 Between the highest and lowest market |
| Kronick and Neyaz,[6] 2019 | California (2015-2017) | 208 | 208 | 1367 Between the highest and lowest hospital |
| Colorado Health Care Policy and Financing,[7] 2019 | Colorado (2017) | 240 | 240 | 121 Between insurance rating regions in state |

In Massachusetts, legislators have pursued a broader response to the state's hospital pricing findings by establishing a Health Policy Commission that sets targets for the rate of overall spending growth (although the commission has limited enforcement capacities). Delaware and Rhode Island followed the Massachusetts example with a similar target-setting effort, and there is pending legislation in Oregon to do the same. Public purchasers are leading the employer response to rising commercial prices. In 2017, Montana's public employee health program announced it would limit hospital payments to 234% of Medicare rates. North Carolina's treasurer followed suit, proposing a figure of 182%, and Oregon passed legislation capping hospital prices for public employees at 200% of Medicare rates. Washington's newly passed "public option" for its health insurance exchange sets its hospital prices at 160% of Medicare.

Private sector employers are also becoming involved. A 2019 survey of 1300 self-insured businesses cited by the Society for Human Resources Management indicated that 12% were considering reference-based pricing for their benefit plans. A group of self-insured employers donated their claims data and helped fund a 2019 RAND study documenting the variation in 25 states.[1] A coalition across Wisconsin, Illinois, and Iowa is now negotiating contracts with hospitals directly based on Medicare prices. These public and private purchaser actions likely need to become widespread to have systemic effects on health care spending over time. An Executive Order from the Trump administration, issued June 24, 2019, may contribute to these efforts. It directs the Department of Health and Human Services to issue rules requiring hospitals to disclose "information based on negotiated rates" in an "easy to understand" format.

However, the black box of commercial pricing will not yield data easily. North Carolina hospitals, for example, have mounted vigorous legislative and social media responses to the state treasurer's proposal to index prices in the state employees' health plan to Medicare rates. In Colorado, a public advisory board refused to sign off on the state's hospital pricing report in response to hospital concerns. Many hospital associations are carefully following the billing legislation being debated nationally, understanding that any "percent-of-Medicare" figure written into law risks establishing a reference price for the industry.

Commercial insurers likewise have had little interest in revealing their rates. Representatives have criticized the recent Executive Order, warning of decreased competition and higher prices, and will likely contest what constitutes "easy to understand" and "information based on negotiated rates." Many price analyses rely on voluntary claims databases, in which insurers decide the rules of disclosure. United Healthcare, for example, announced earlier this year that it will no longer submit data to the Health Care Cost Institute, leaving the database with only 3 national plans. In 2016, the Supreme Court interpreted federal Employee Retirement Income Security Act laws as exempting the administrators of self-insured health plans from requirements to submit their clients' claims data to state all-payer claims databases, and large employers have thus far been reluctant to submit data voluntarily.

Regardless of whether the United States adopts Medicare-for-all, recent state and employer action suggests that it may move toward "Medicare-reference-pricing-for-more." Using some multiple of fee-for-service Medicare rates as a common standard for assessing and setting commercial insurer prices increases institutional accountability and public awareness. Higher-paid hospitals are forced to justify their generous payment levels and important public conversations occur regarding health care value and funding priorities.

Policy discussions about the adequacy of Medicare rates, the price differential paid by employers and individuals, and why that markup should differ among hospitals and physicians caring for the same population of patients should be informed by data-driven analysis and vigorous public debate. The current system, in which private contracts are shrouded in secrecy, leads to costs tethered to the negotiating leverage of health care organizations instead of the value they offer, and patients and employers are paying the price.

ARTICLE INFORMATION

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