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Gap Between Private Insurance and Medicare Hospital Payments Increased in 2018

On September 18, 2020, the nonprofit *Research and Development* (RAND) Corporation published a research report, which found that private insurance companies pay prices that are on average 240% higher than what Medicare pays for the same hospital services.[1]

The report analyzed data from 2016 through 2018 across 49 states and Washington D.C.[2] The only excluded state was Maryland, for which data was collected but not included in the study because of the state's all-payor rate setting program, where hospitals by default charge prices equal to private payors and Medicare.[3] RAND data included only community hospitals such as *inpatient prospective payment system* (IPPS) hospitals and *critical access hospitals* (CAHs).[4] Other facilities such as specialty hospitals, *skilled nursing facilities* (SNFs), inpatient rehabilitation facilities, and *Veterans Administration* (VA) facilities were excluded from the data.[5] This study was conducted based on a convenience sample[6] of 120 self-insured employers of various sizes and from various industries.[7] Data also came from *all-payor claims databases* (APCDs), but only in six states.[8] APCDs are state databases of claims data and provider files reported by insurers, which are usually required by state mandates.[9] In total, the sample included data from over 3,000 hospitals, almost 48 million claims, and $33.8 billion in spending by private payors.[10] In order to make hospital comparisons, RAND created a pricing algorithm based on Medicare's fee schedules and compared these payments to two different ways of calculating private payments: (1) *standardized prices*,[11] where standardized units are created based on average intensity of services, and (2) *relative prices*,[12] where Medicare reimbursement is used a benchmark from which ratios are calculated.[13]

To ensure more reliable and applicable pricing information, the RAND study has been expanding their report each year, increasing from one state in the first edition in 2017 to all but one in this third edition.[14] This edition also included professional fees, or the amounts charged by physicians, which is less commonly found in research on private and public payor payments to hospitals, as many choose to only focus on hospital facility fees.[15]

Specifically, the report found that RAND-calculated relative prices for private payors were 231% and 267% more expensive than Medicare for inpatient and outpatient services, respectively, with an average discrepancy of 247%.[16] The variation between states was significant: states such as Alaska, Florida, Tennessee, South Carolina, and West Virginia had relative prices upwards of 325% of Medicare, while others such as Arkansas, Michigan, and Rhode Island, had prices less than 200% of Medicare.[17] For this data, the variations in payments between the $33.8 billion in private spending and the $14.1 billion in simulated Medicare payments made for a difference of $19.7 billion, or a potential savings of 58% over private insurance costs.[18] In fact, the current study shows a compounded rate of increase of 5.1% per year, much higher than 1.6% that was estimated in the 2019 edition of this report.[19] The inclusion of more employers as well as professional fees, however, may be contributing factors to this large difference between studies.[20]

The RAND report also included data as to how quality and safety ratings were related to prices above Medicare. To do this, hospitals were split into three groups: low prices (less than or equal to 1.5 times Medicare rates), medium prices (between 1.5 and 2.5 times Medicare rates), and high prices (greater than or equal to 2.5 times Medicare rates).[21] Hospice Compare data, including star quality ratings, were pulled from the *Centers for Medicare and Medicaid Services* (CMS), and safety data was obtained from the Leapfrog Group. The data showed high-quality, low-cost options for employers: while high-cost hospitals show higher proportions of five-star ratings than low-cost hospitals, 91% of low-cost hospitals received three or more stars, and 17% of high-cost hospitals received two stars or under.[22] For safety ratings, letter grades across hospital costs were similar, with 51% of those in the low-cost category and 60% in the high-cost category earning a grade of A or B.[23] On the other end of the grading spectrum, 14% of low-cost hospitals and 6% of high-cost hospitals scored a grade of D or F.[24]

With this report, RAND aims to combat the "*high and rising health care costs*" that employers face.[25] Employers, as discussed in the report, may often rely on insurers or others to negotiate fair contracts with providers.[26] However, a lack of price transparency from hospitals makes it difficult to compare hospital prices and value.[27] Further, if employers have their prices negotiated for them, they often have no way to evaluate the value of these contracts.[28] The data also indicate no correlation

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between the prices a hospital charged to commercial payors and the amount of patients with public insurance, contrary to the so-called *cost-shifting* idea that many propose as a primary reason for this widening gap between private and public costs.[29] The study's lead author attributed this gap to other factors such as reputation, quality, or market dominance outside of patient care factors[30] and hopes that reports and data such as this will help give employers a better position for negotiating, similar to that gained by insurers and hospitals through consolidation, and will further equip employers with the knowledge that low-cost hospitals in many areas can also have similar safety and quality ratings as high-cost hospitals.[31] Publishing this data may allow employers to demand better value for their costs of care, which have been a cause of concern among employers as their healthcare costs increase at a much faster rate than government payor spending.[32] RAND also hopes that the data will benefit the 153 million Americans, or 57% of the nonelderly population, who have health insurance through employers.[33] While many providers and insurers are enacting "*gag clauses*" to prohibit greater price transparency to employers or patients, the RAND study seeks to shine a light on payment gaps and the costs of healthcare.[34]

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1 "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative" By Christopher M. Whaley, et al., RAND Corporation, 2020, https://employerptp.org/wp-content/uploads/2020/09/RAND-3.0-Report-9-18-20.pdf (Accessed 9/18/20), p. 13.
2 *Ibid*.
3 *Ibid*, p. 3.
4 *Ibid*.
5 *Ibid*.
6 In this context, a *convenience sample* means that only employers who chose to participate were included in the data. This was not a random sample of all employers.
7 Whaley, et al., RAND Corporation, 2020, p. 6.
8 The six states were Connecticut, Colorado, Delaware, Maine, New Hampshire, and Rhode Island. *Ibid*, p. 6.
9 "All-Payer Claims Databases" Agency for Healthcare Research and Quality, February 2018, https://www.ahrq.gov/data/apcd/index.html (Accessed 9/21/20).
10 Whaley, et al., RAND Corporation, 2020, p. 13.
11 In this report, standard prices are defined as the "*average allowed amount per standardized unit of service, where services are standardized using Medicare's relative weights*." *Ibid*, p. vii.
12 In this report, relative prices are defined as the "*ratio of the actual private allowed amount dived by the Medicare allowed amount for the same services provided by the hospital*." *Ibid*, p. vii.
13 *Ibid*, p. 8-10.
14 *Ibid*, p. 2; "RAND 1.0" Employers' Forum of Indiana, https://employerptp.org/rand-1/ (Accessed 9/21/20).
15 "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative" By Christopher M. Whaley, et al., RAND Corporation, 2020, https://employerptp.org/wp-content/uploads/2020/09/RAND-3.0-Report-9-18-20.pdf (Accessed 9/18/20), p. 2-3.
16 Whaley, et al., RAND Corporation, 2020, p. viii.
17 *Ibid.*
18 *Ibid*, p. 13.
19 *Ibid.*
20 *Ibid.*
21 *Ibid*, p. 18.
22 *Ibid*, p. 19.
23 *Ibid*, p. 19-20.
24 *Ibid*, p. 20.
25 *Ibid*, p. 1.
26 *Ibid*.
27 *Ibid*.
28 *Ibid*, p. 2.
29 "Gap between what private insurers and Medicare pay hospitals is growing" By Tara Bannow, Modern Healthcare, September 18, 2020, https://www.modernhealthcare.com/payment/gap-between-what-private-insurers-and-medicare-pay-hospitals-growing (Accessed 9/18/20).
30 *Ibid*.
31 Whaley, et al., RAND Corporation, 2020, p. 1-4.
32 *Ibid*, p. 2.
33 *Ibid*, p. 1.
34 *Ibid*.

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