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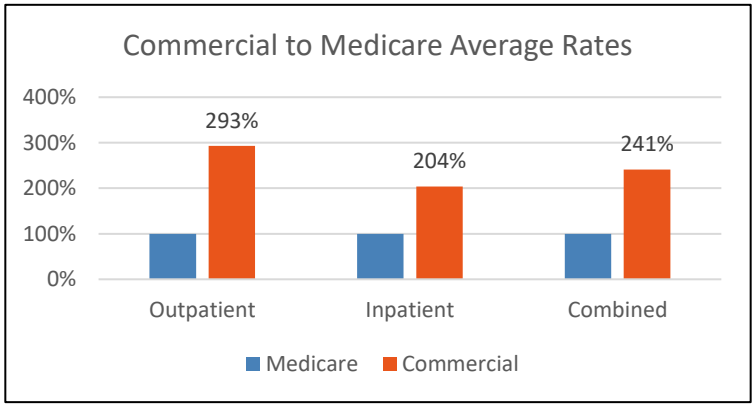
Summary & Takeaways

RAND Corporation Study: Prices Paid to Hospitals by Private Health Plans are High Relative to Medicare and Vary Widely

Summary[1]

Employer sponsored commercial insurance paid 241 percent of Medicare Fee-For-Service prices in 2017, as reported in an attention-grabbing study released by RAND Corporation in early May 2019. Same services, same hospitals, yet those with commercial insurance paid more than double the price of those with Medicare. Further, the research shows there is wide variation by hospital provider within states, as well as variation in the aggregated average among states. Employers and hospitals will find the report especially interesting. This study has caught the attention of media outlets who focused on the 241 percent overall average number. There has also been some local coverage within the 25 states the study had data on, as the report appendix shows average percent of Medicare by hospital provider. In this article we highlight the report findings and share our thoughts on how employers and hospitals can use this information. Employers to drive down insurance rates and hospitals to protect their market position.



First, a Little About Commercial Insurance Funding

Most people in the U.S. obtain insurance coverage through their employers.[2] Employers can choose to be self-insured or fully insured. This decision is based on the financial resources the employer has and the level of risk they choose to be responsible for. Some large employers structure their health insurance offerings to employees through a form of self-insurance, where the employer funds claims and thus bears full risk. This approach can reduce costs for employers, as they won't pay fees and mark up associated with fully insured plans. Further there is more flexibility in designing plans under a self-insured model, such as determining in network providers. The other predominate insurance structure is fully insured. Under this model, the employer pays the insurance company a fixed amount per member and the insurance company bears full risk of the actual claims. Under both models, the health insurance company negotiates contracts with healthcare providers to be in network. These contracts specify fees providers will be paid by service offered. These contracts between insurer and hospital are often not transparent to employers, and frequently there are clauses within provider/insurer contracts that prohibit disclosing price information.

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[1] White, Chapin; Whaley, Wray, Christopher. "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely, Findings from an Employer-Led Initiative." RAND Corporation.https://www.rand.org/pubs/research_reports/RR3033.html. Accessed 5.15.2019.

[2] "Health Insurance Coverage of the Total Population 2017." Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population. Accessed 7.16.2019.

What Did RAND Analyze?

RAND analyzed data from 25 states for years 2015 to 2017 for a segment of employer sponsored commercial insurance claims related to hospital facility inpatient (IP) and outpatient (OP) services only (no professional services). Commercial net allowed rates by service (Diagnostic Related Group (DRG) code for IP and Ambulatory Procedure Code (APC) for OP), were compared to what the corresponding Medicare Fee Schedule rates would have been for similar services. individual insurance plans were not identified in the report. Thus, there is not the ability, for example, to measure if Aetna at facility Y is more expensive on average than Anthem at the same facility. See Table 2 below for more on the study methodology.

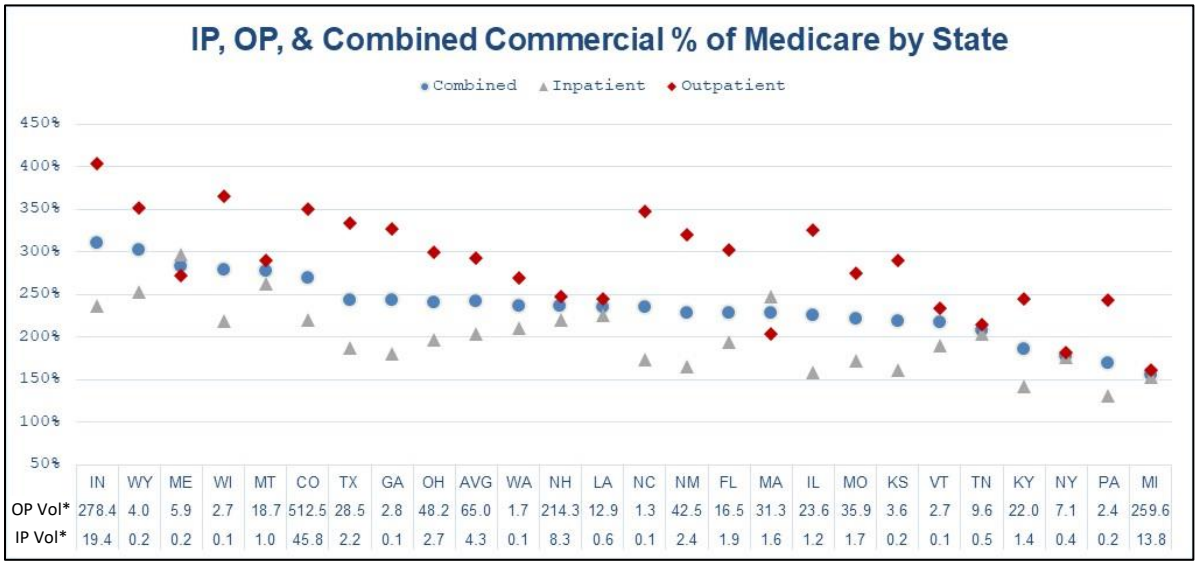
Summary RAND Findings

Overall Commercial rates of the data analyzed were 241 percent of Medicare rates in 2017. By care setting, outpatient rates averaged 293 percent, and inpatient rates averaged 204 percent of Medicare. Also, there was wide variation of average price over Medicare by state. The RAND study doesn't state a conclusion on what drives this price variation. The study does suggest contributing factors could be the lack of information most employers have into the contract rates between hospital providers and insurers, thus limiting the ability to adjust plan design. A secondary contributing factor could be the number of in network providers within plans. Employers have resisted reducing the number of providers in-network. With little concern of getting dropped from a network, providers have more leverage in rate negotiations with insurers. The study further suggests markets with higher levels of consolidation among healthcare insurers or large employers willing to directly contract with healthcare providers could reduce rates. We expect future studies to attempt to answer the causes of this provider reimbursement variation.

Of importance, of the 25 states analyzed, only 4: Indiana, Colorado, New Hampshire, and Michigan had over $200 million of commercial spend per state analyzed. Even in these four states, the data does not represent the full commercial payer market. The fact that limited data was used can be a talking point for providers, as the study findings may not fully reflect reality. To validate this study's findings, RAND is recruiting additional employers and including more states, for a 2020 study.

Chart 1: Inpatient, Outpatient, and Combined average percent of Medicare rates by state.

The variation in average state Commercial service reimbursement rates compared to Medicare is large. For example, Indiana is over 300 percent combined inpatient and outpatient and Michigan is approximately 150 percent. There will be a lot of interest in figuring out the drivers of this variation.



	IN	WY	ME	WI	MT	CO	TX	GA	OH	AVG	WA	NH	LA	NC	NM	FL	MA	IL	MO	KS	VT	TN	KY	NY	PA	MI
OP Vol*	278.4	4.0	5.9	2.7	18.7	512.5	28.5	2.8	48.2	65.0	1.7	214.3	12.9	1.3	42.5	16.5	31.3	23.6	35.9	3.6	2.7	9.6	22.0	7.1	2.4	259.6
IP Vol*	19.4	0.2	0.2	0.1	1.0	45.8	2.2	0.1	2.7	4.3	0.1	8.3	0.6	0.1	2.4	1.9	1.6	1.2	1.7	0.2	0.1	0.5	1.4	0.4	0.2	13.8

* Volume in thousands. IP DRGs, OP APCs

RAND's Recommendations

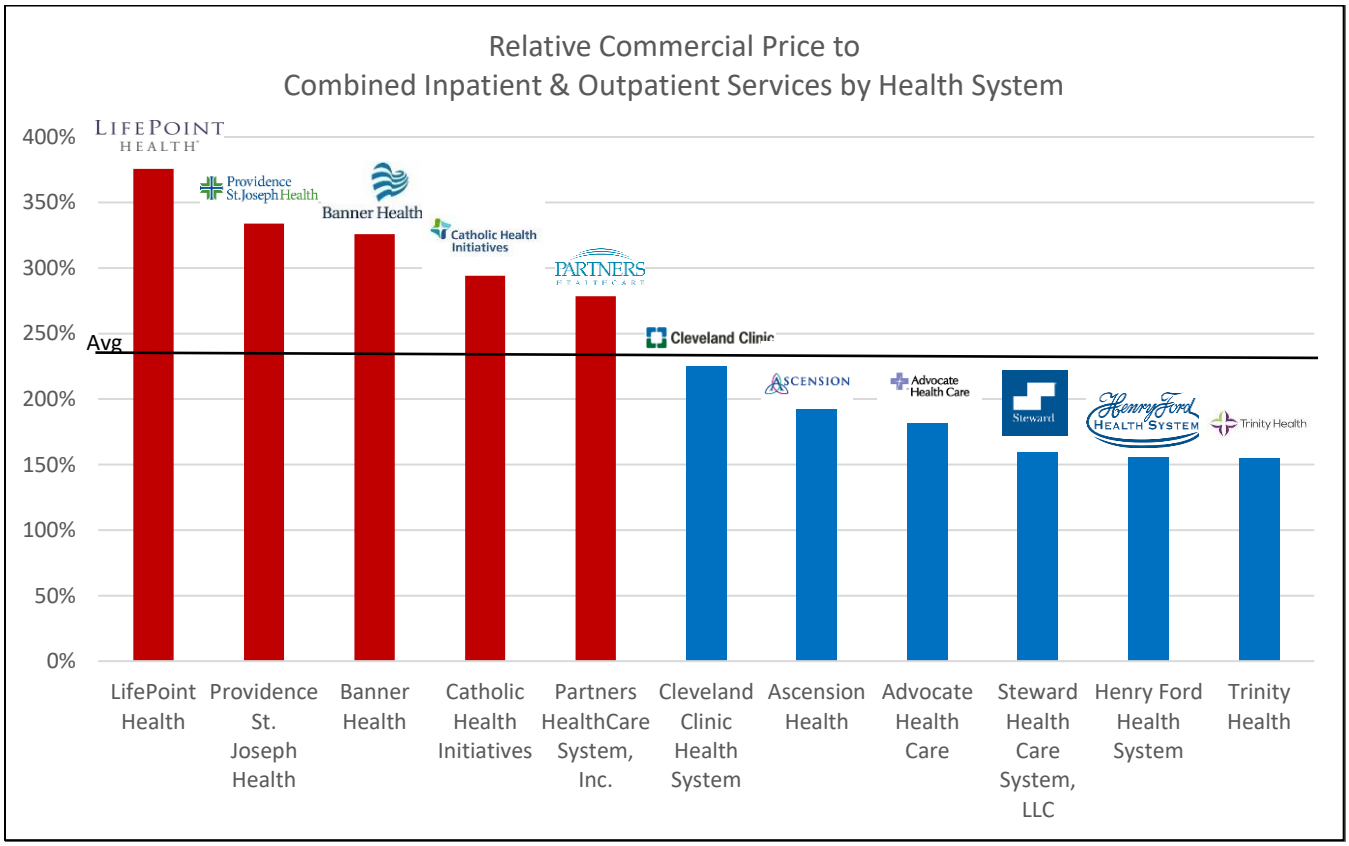
1. **Insurers and Employers should limit discount of charge related contracts** and attempt to negotiate contracts based on percent of Medicare contracts. It is acknowledged that this can be difficult.
2. **Employers should expand participation in all payor claims databases to expand information transparency.** These databases now are available in 24 states (+4 more that are in process of implementing). Data standards, availability, and cost to obtain data from these need to be improved to extract more value out of them.
3. **Allow employers to buy into Medicare or provide a public option** for individuals to purchase.

Variation by Provider

The appendix Excel spreadsheet from the RAND study is probably the most interesting part of the study. It is worth a review for providers in the 25 states analyzed. The variance in percent of Medicare average commercial rates by facility and system is stark. Local media has and will continue to take note of this information, writing about this price disparity among hospitals in local markets.

Below in Chart 2, is a list of well-known health systems and their percent of Medicare average reimbursement for the commercial claims analyzed by RAND. With more of this type of information known, employers and patients may start asking questions about where to spend their money. Highly reimbursed providers should be prepared to present the value proposition to justify their relatively higher rates.

Chart 2



All health systems above had at least 6,000 combined services (IP & OP) analyzed within the RAND study.

Our Takeaways

1. **The report shouldn't be considered conclusive, but it is a useful data point.** The data in the report is more complete for some states versus others, and for some hospitals versus others. It is also limited to hospital care settings. There are some very low discharge/service volume states and facilities that may not tell the full picture.
2. **More price transparency information will become available to the public**. Healthcare price variation continues to be a national focus. This report and a recent HHS proposal and Executive Order[3] for providers to publish net insurance rates by service, are just the beginning. Actions on price transparency are gaining momentum.
3. **The appendix spreadsheet to the RAND study has information that will bolster payor negotiating leverage**. While, specific insurer commercial insurance rates are not shown, the overall relative price for inpatient, outpatient, and these combined by facility is available in the appendix table. Payors can use this information to negotiate rates down in their favor. Commercial payors will have leverage and now data points for how their contracts fare vs the average by facility.
4. **Self-Insured employers will likely play a more engaged role. This includes selecting their insurance administrator, crafting in network providers for the plans, or directly contracting with healthcare providers**. There are large savings opportunities for employers by steering patients to lower cost providers (see Table 1). The more rate variation by facility is known, the easier cost savings related to steering patients to preferred providers can be quantified. Further, the U.S. economy has recently been strong, to attract talent employers have been reluctant to narrow the network of facilities for their benefit plans. Reducing employee choice with a skinny network, could be more palatable to employers in a down business cycle.
5. **Providers should keep a continued focus on differentiators.** What makes your facility worth paying more for services? E.g. higher quality, more consumer focused. Prove your value.
6. **Providers should formulate talking points before media outlets, insurers, or employers start to ask**. E.g. Differentiated services as described above, discussion on study limitations.
7. **Language barring insurance companies from disclosing negotiated service rates to providers may be struck from new agreements.** The draft Lower Healthcare Costs Act of 2019[4] has draft language that would eliminate gag clauses that currently restrict the disclosure of service rates to consumers and plan sponsors.
8. **The report does not conclusively determine what drives price variation in markets.** Future studies will likely attempt to answer this. E.g. provider consolidation, certain insurance types. The result could impact provider or insurer merger and acquisition activity.

In summary, healthcare price transparency will give employers and payors new data to attempt to drive down negotiated rates with providers or steer patients to lower cost providers. High cost providers should start preparing for this increased price transparency by focusing on what differentiates them outside of cost.

Table 1 - Health Plan Narrow Network Cost Savings Example

[3] "Executive Order on Improving Price and Quality Transparency in Healthcare to Put Patients First, Issued 06/24/2019. www.whitehouse.gov. Accessed 7.16.2019

[4] "Lower Healthcare Costs Act of 2019." 116th Congress, 1st Session. https://www.help.senate.gov/imo/media/doc/LHCC%20Act%20Discussion%20Draft%205_23_2019.pdf. Accessed 7.15.2019

One of tools that employers and insurance companies are likely to use in plan design, as a result of this RAND study and subsequent studies, will be to continue to refine in-network providers. The variation in commercial rates by provider is large. The more variation, the higher the potential cost savings to employers by directing employees to go to lower cost providers. A stylized example of potential savings to self-insured employers is shown below. Note, there is a lot that goes into having an adequate provider network outside of just cost that should be factored in these decisions (e.g. employee preference, geography, specialty needs).

Company Health Plan Current Statistics

A large self-insured employer health plan has 10,000 covered lives and has $120M of current health plan spend.

Covered - Employees + Beneficiaries	10,000
Current Plan Cost Per Covered Employee	$ 12,000
Total Plan Costs	$ 120,000,000

Current Healthcare Provider Company Plan Usage

Currently there are three health systems in-network on the employer's healthcare plan. These facilities are used equally by employees and their beneficiaries. However, the average percent of Medicare the employer's commercial plan pays these health systems for services is very different.

Health System	Current Plan Use	Avg Percent of Medicare
Health System X	33 percent	215 percent
Health System Y	33 percent	275 percent
Health System Z	33 percent	315 percent

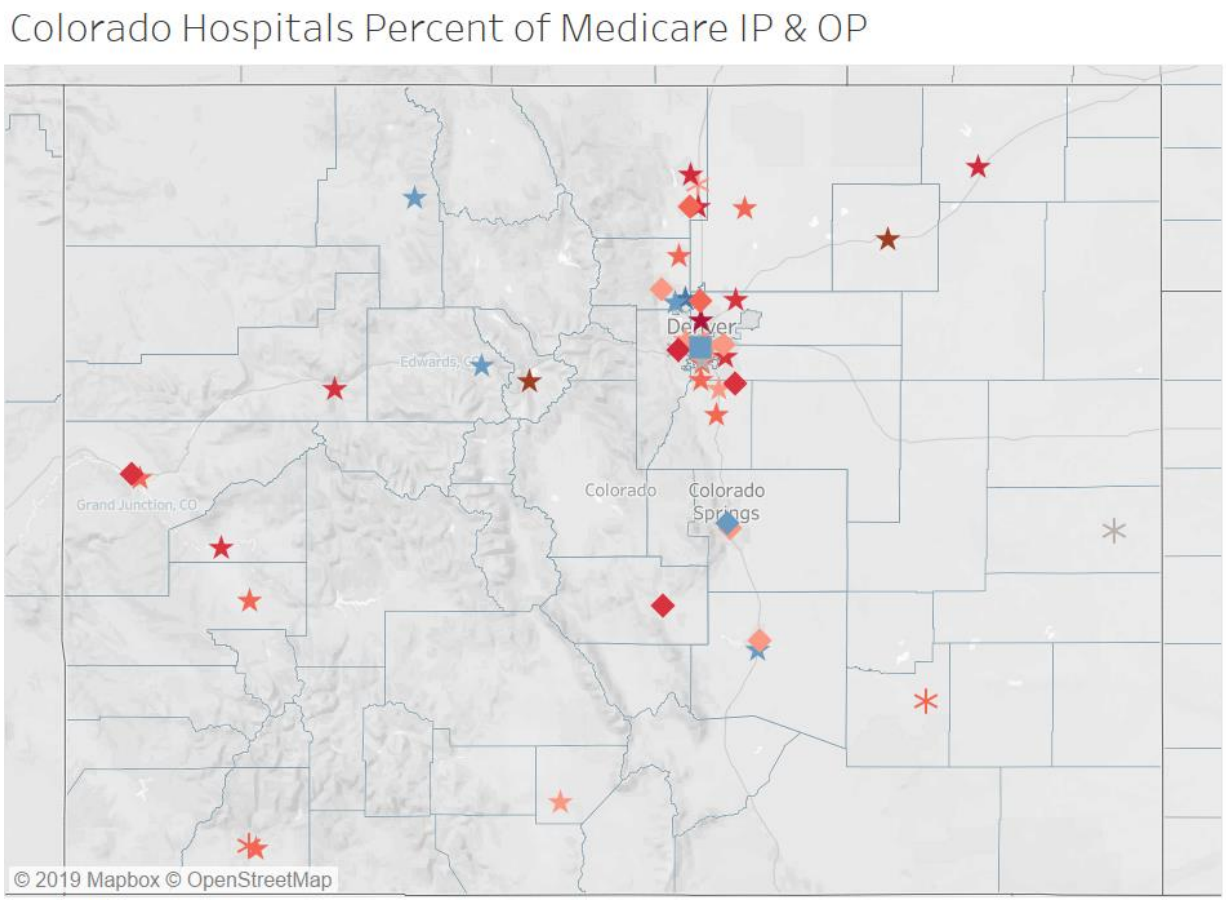
Impact of Narrowing the Network of Providers from the Company Plan

Employer sees the difference in average plan reimbursement among the providers and decides to narrow the network. Employer drops Health System Z, the highest reimbursed provider at 315 percent of Medicare, from being in-network. Employee insurance plan healthcare utilization shifts to being equal between Health System X and Y. As a result, the overall employer plan spend as a percent of Medicare drops 21 percent and the total plan costs to the employer decreases by $9.3M per year. This represents sizable savings for employers and is not that difficult to do, especially equipped with the information on service rate transparency.

Health System	Current Plan Use	Revised Plan Use	Change
Health System X	33 percent	50 percent	17 percent
Health System Y	33 percent	50 percent	17 percent
Health System Z	33 percent	0 percent	-33 percent
Avg percent of Medicare	266 percent	245 percent	-21 percent
Total Plan Costs	$ 120,000,000	$ 110,671,937	$ (9,328,063)

Chart 3 – Relative Medicare Price by Facility in Colorado

Of the states analyzed, Colorado had some of the highest service reimbursement as a percentage of Medicare at 269% combined inpatient and outpatient. The below map looks at non-critical access hospitals across the state relative service costs as well as each facility's Hospital Star quality rating. Facilities with lower relative service reimbursement and higher Medicare Star quality rankings may become more attractive to plans (denoted by blue stars below). This type of analysis, completed in any market, can help insurers and employers with network decisions.



	Relative Medicare Combined Inpatient & Outpatient
	+500% of Medicare
	400% to 450% of Medicare
	350% to 400% of Medicare
	300% to 350% of Medicare
	250% to 300% of Medicare
	200% to 250% of Medicare
	100% to 200% of Medicare
	No Data

Hospital Compare 5-Star Rating (October 2018, N/A = Not Available)
■ 2
◆ 3
★ 4
★ 5
✱ NA

Table 2 – Study Data Sources

Below find detail on the data sources used by RAND.

Section	Detail
Timeframe	2015-2017
Claim sources	• All payor claims databases - CO & NH. 2M Covered Lives (CLs) • ~50 self-insured employers, 12 from IN and the rest from various states. 1.2M CLs • Health plans that chose to participate. 800K CLs • Sources in total represented 4 million CLs
Claim Types	Inpatient and Outpatient. Outpatient data was more complete than Inpatient. In and Out of Network cases included
Facilities	Hospitals only. Community and Critical Access Hospitals only. 1,598 facilities in total
States	25 in total. CO, FL, GA, IL, IN, KA, KY, LA, ME, MA, MI, MO, MT, NH, NM, NY, NC, OH, PA, TN, TX, VT, WA, WI, WY
Other	Value Based Care payments were removed. Uncompensated care claim based Medicare add on payments were normalized

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