

RAND Hospital Price Transparency Project

The Alliance Spring
Symposium



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Acknowledgments

- Funding provided by the Robert Wood Johnson Foundation, Arnold Ventures, and participating employers
- Study conceptualized by Employer's Forum of Indiana

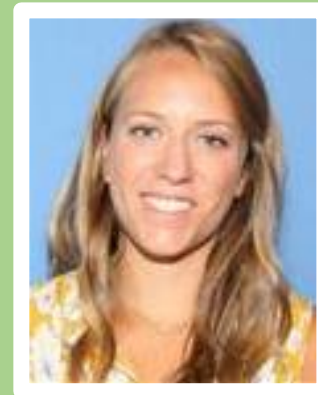
Study team



Rose Kerber
Research
Programmer



Aaron Kofner
Research
Programmer



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Research
Programmer



Brian Briscoe
Quantitative
Analyst

Employer-sponsored plans cover half of Americans



\$1.2 trillion

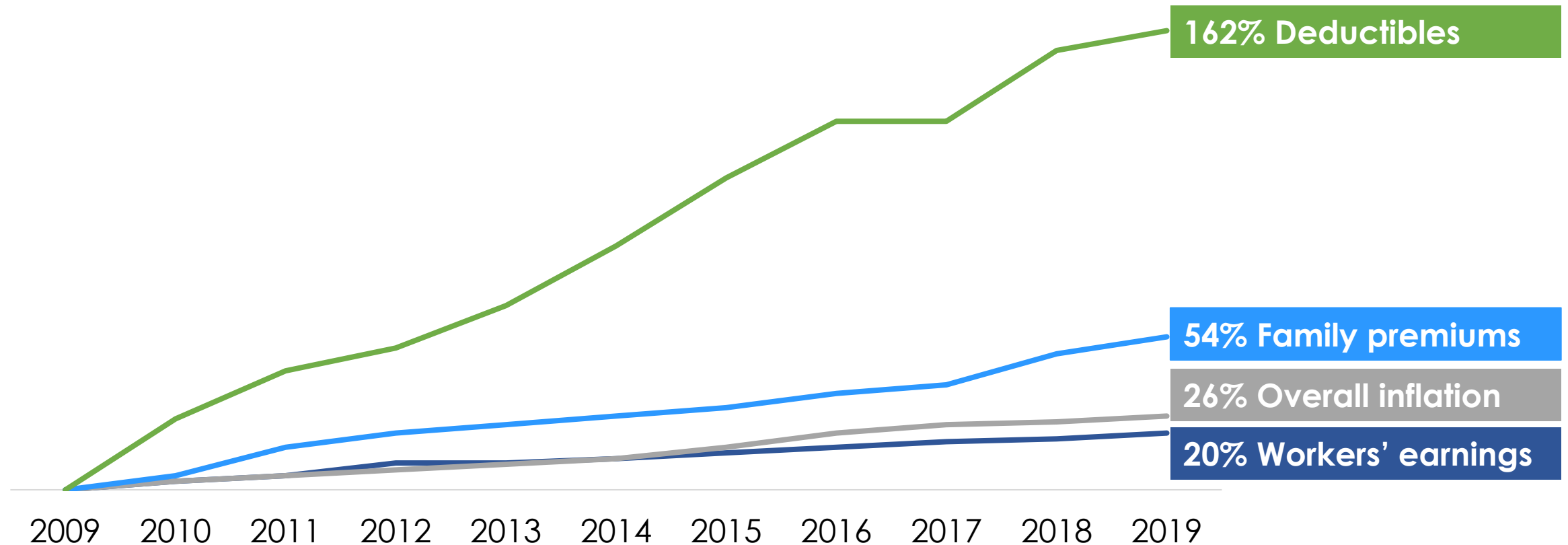
health care costs in 2018

\$480 billion

hospital costs in 2018

160 million people

Over the past decade, premiums and deductibles have outpaced wages



Self-funded employers have a fiduciary responsibility to monitor health care prices

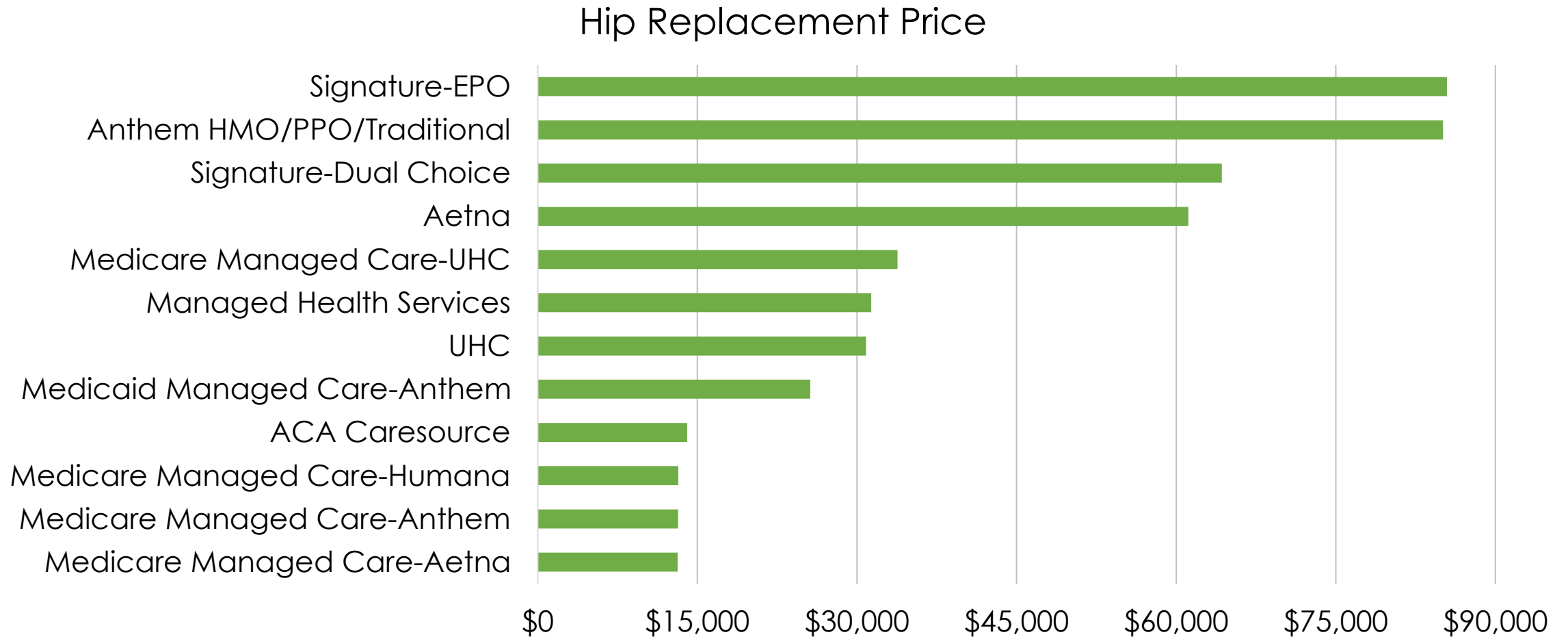
“Fiduciaries have a responsibility to “act solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them.”

—Department of Labor

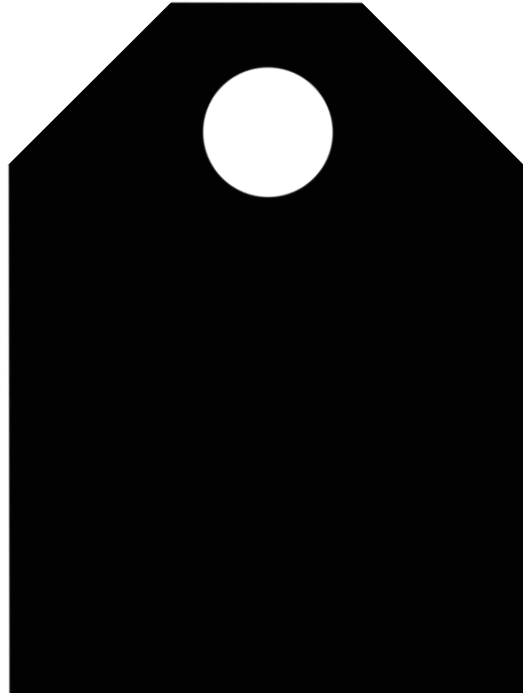


How can self-funded plans fulfill fiduciary obligations without knowing prices?

Econ 201: Prices make sense in efficient markets

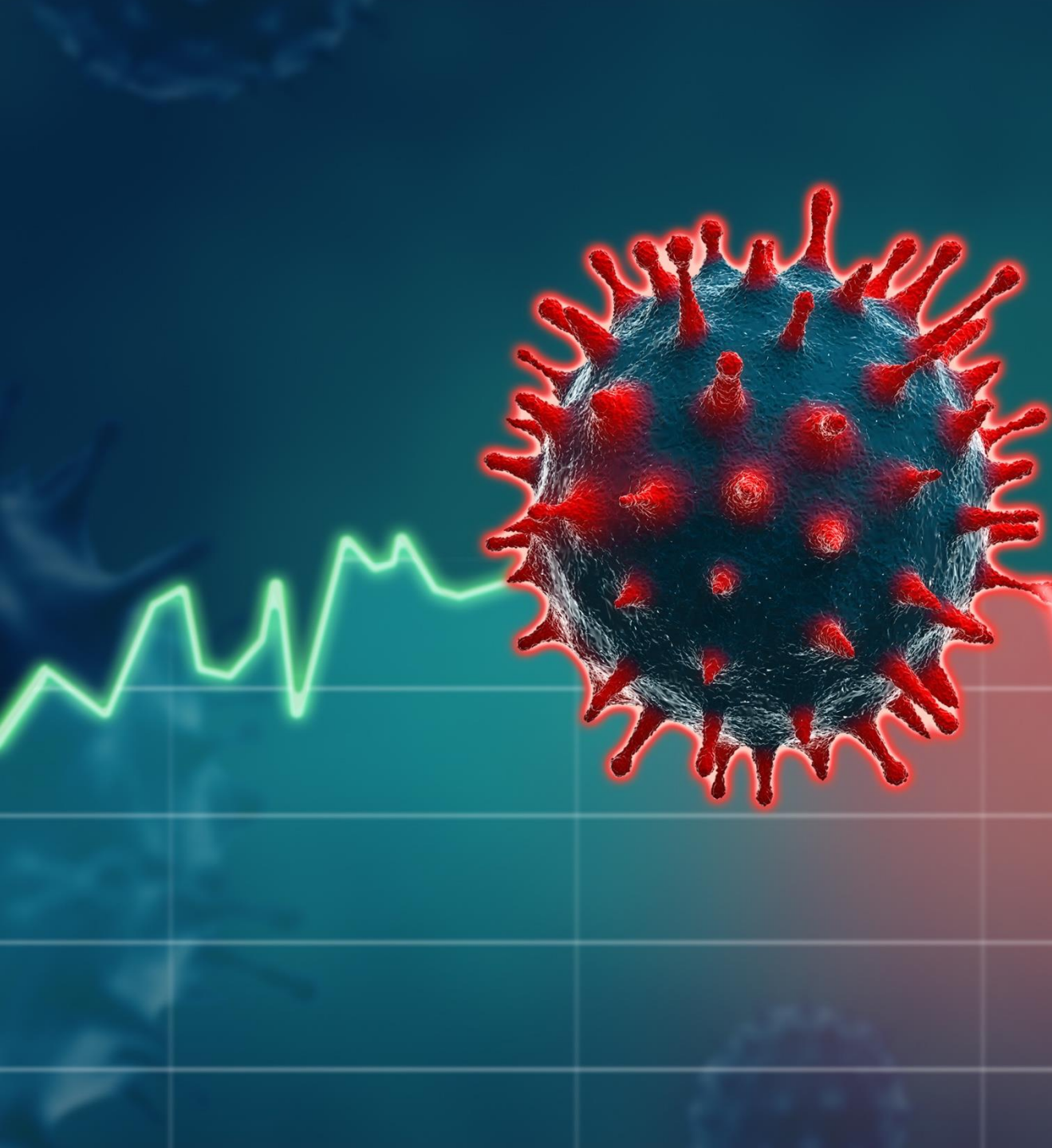


Why did RAND undertake this study?



- We do not know what the “right” price is for hospital care
- Self-funded employers cannot act as responsible fiduciaries for their employees without price information

Employers can use the information in this report—
together with knowledge of their own employee
populations—to decide if the prices they and their
employees are paying align with value



Hospital prices in the time of COVID-19

- COVID-19 is placing enormous financial pressure on both hospitals and employers
- Hospitals and health professionals are critical members of their communities
- Health benefits are one of the largest expenses for employers
- Now more than ever, employers need transparent information about hospital prices

RAND's hospital study journey

Phase 1

Phase 2

Phase 3

Indiana

25 states

49 states (not Maryland)

Employers

Plus health plans and 2 All-Payer Claims Data (APCD)

Plus 4 APCDs

Facility fees

Plus inpatient/outpatient fees

Plus professional fees

Relative prices

Plus standardized prices

Plus service-line prices

RAND 4.0

Phase 1

Phase 2

Phase 3

Phase 4

Indiana

25 states

49 states (not Maryland)

Plus DC

Employers

Plus health plans and 2 APCDs

Plus 4 APCDs

Plus 5 more APCDs

Facility fees

Plus inpatient/outpatient fees

Plus professional fees

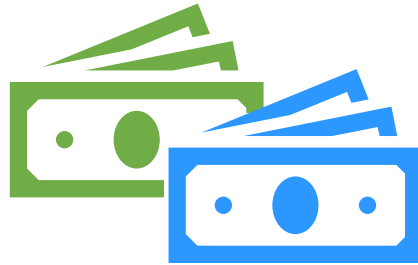
Relative prices

Plus standardized prices

Plus service-line prices

Plus ASC (Ambulatory Surgery Centers) prices and COVID hospitalizations

RAND 4.0



Obtain claims data from

- self-funded employers
- APCDs
- health plans

Measure prices in two ways

- relative to a Medicare benchmark
- price per case-mix weight

Create a *public* hospital price report

- posted online, downloadable
- named facilities & systems
- inpatient prices & outpatient prices

Create *private* hospital price reports for self-funded employers

Comparing prices can be challenging

- Every hospital is different and performs different services
- The Medicare system can help us standardize and make an “apples-to-apples” comparison

We make an apple pie—but with two recipes



Recipe #1: Percent of Medicare

- What do employers pay relative to what Medicare would have paid at the exact same hospitals?
- Easy to interpret and compare across hospitals
- Medicare adjusts for cost of living and wage differences



Recipe #2: Standardized prices

- Medicare has figured out how much more to pay for different services

For example: Medicare pays 34.65 times for a heart transplant (DRG 103) than for chest pains (DRG 143)

We can use these weights to

- Make comparisons across hospital services
- Compute average "walk out the door" amount

- Don't have to worry about teaching, Disproportionate Share Hospital (DSH), etc. payments



Comparison to Medicare



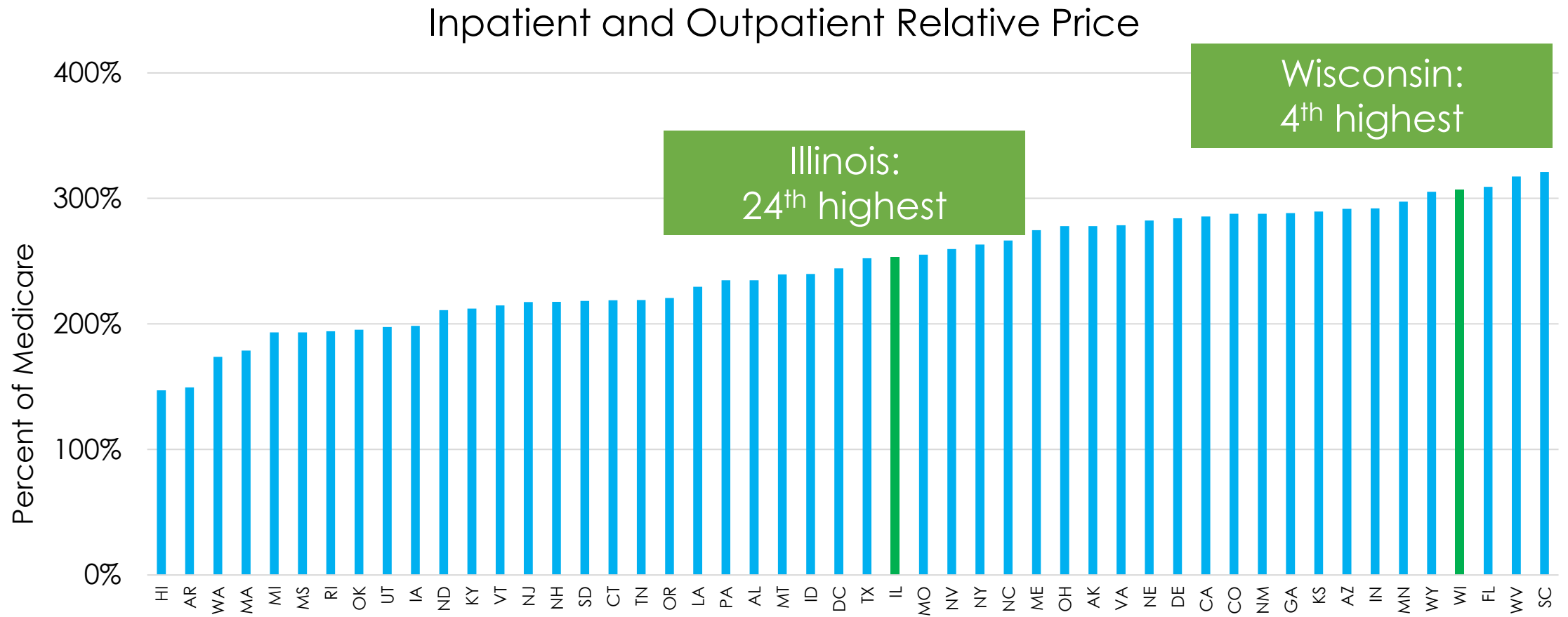
RAND'S RECIPE

- We leverage the Medicare payment system as a benchmark, not as a price endpoint
- Medicare prices and methods are empirically based and transparent
- Benchmarking to Medicare allows employers to compare prices between hospitals, relative to the largest purchaser in the world

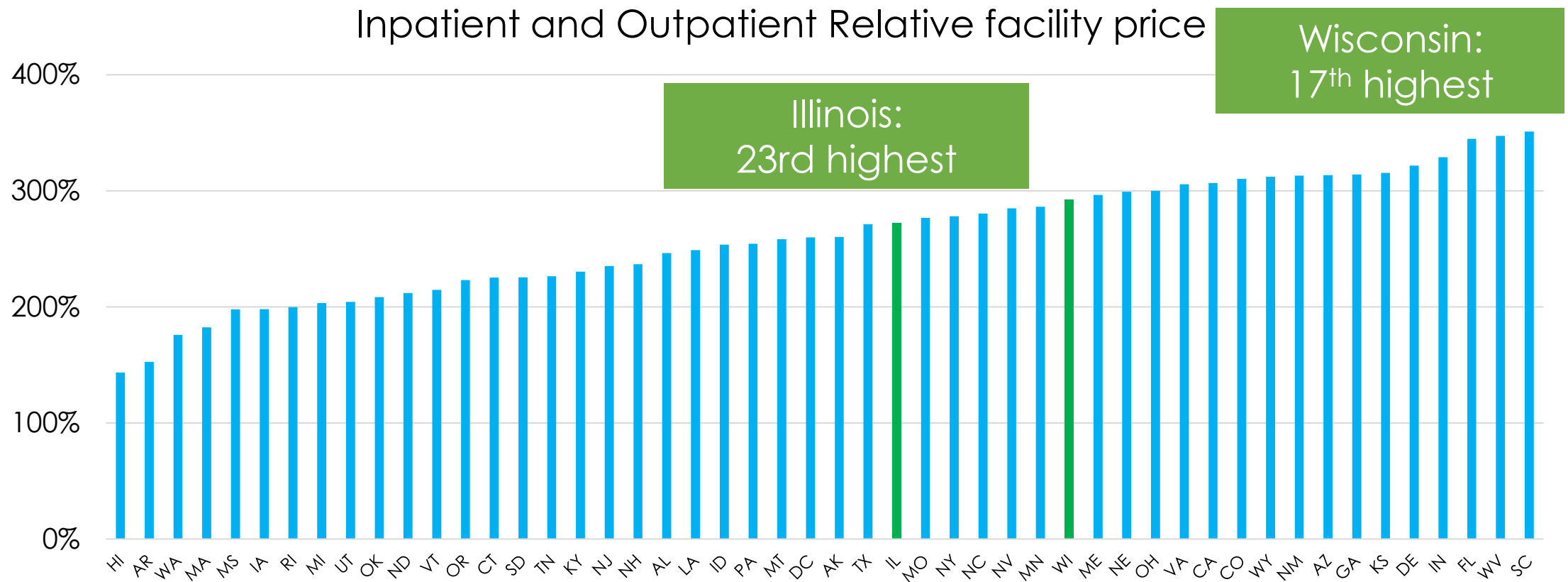
Main findings

- Over 4,000 hospitals and 4,000 ASCs
- Wide variation in hospital prices across states
- In most states, facility fees are higher than professional fees
- Prices for COVID hospitalizations mirror inpatient prices
- Prices for Ambulatory Surgical Centers (ASCs) lower than Hospital Outpatient Departments (HOPDs)

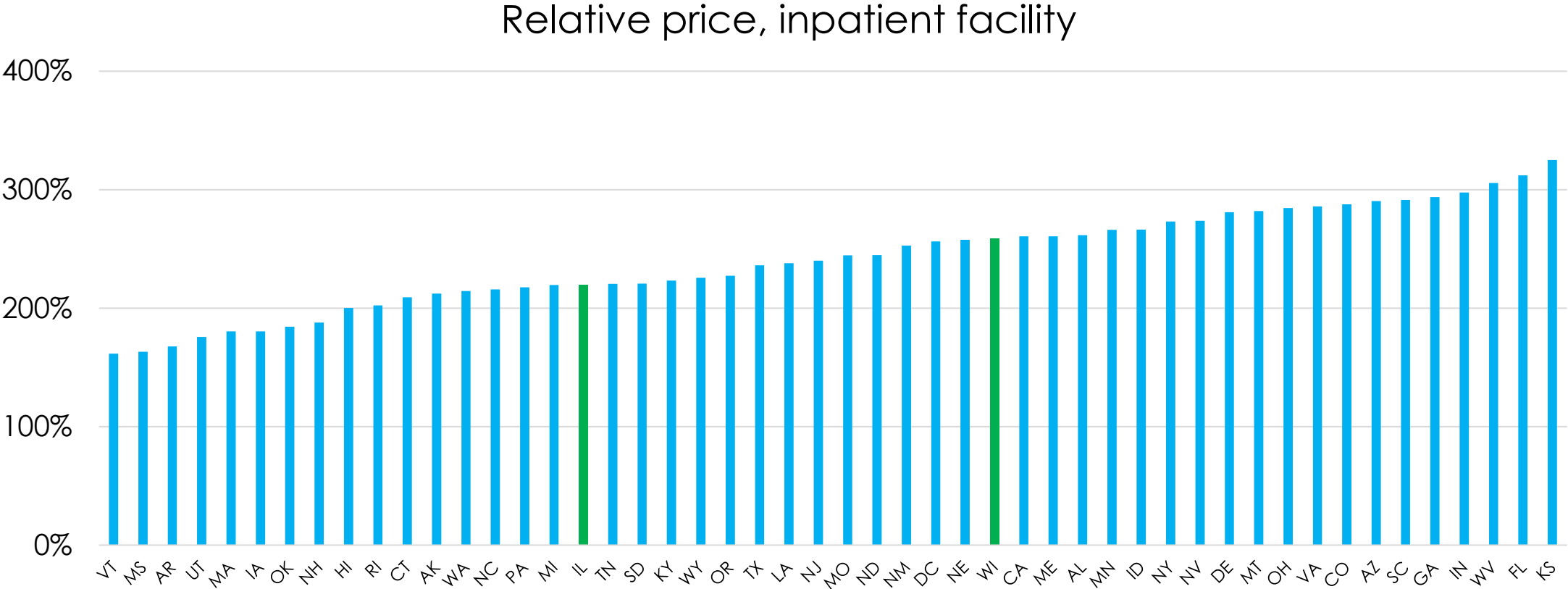
Relative prices vary widely



IL and WI facility prices are middle of the pack relative to Medicare

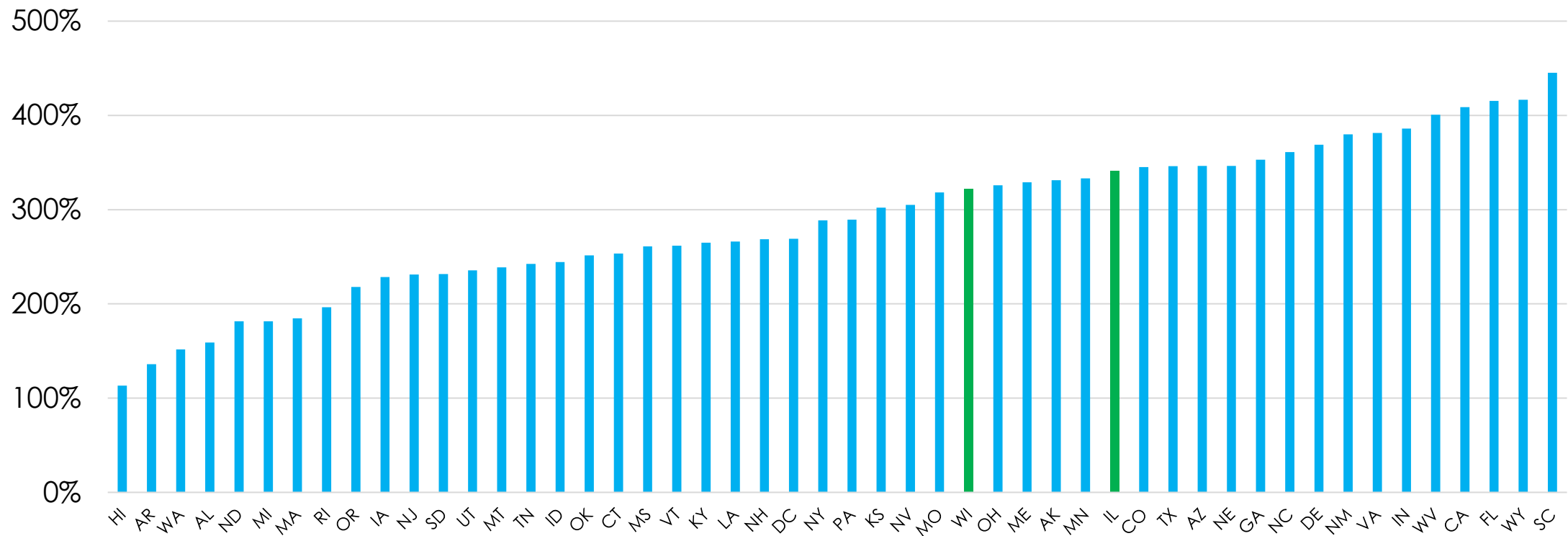


IL and WI Inpatient facility prices are middle of the pack relative to Medicare



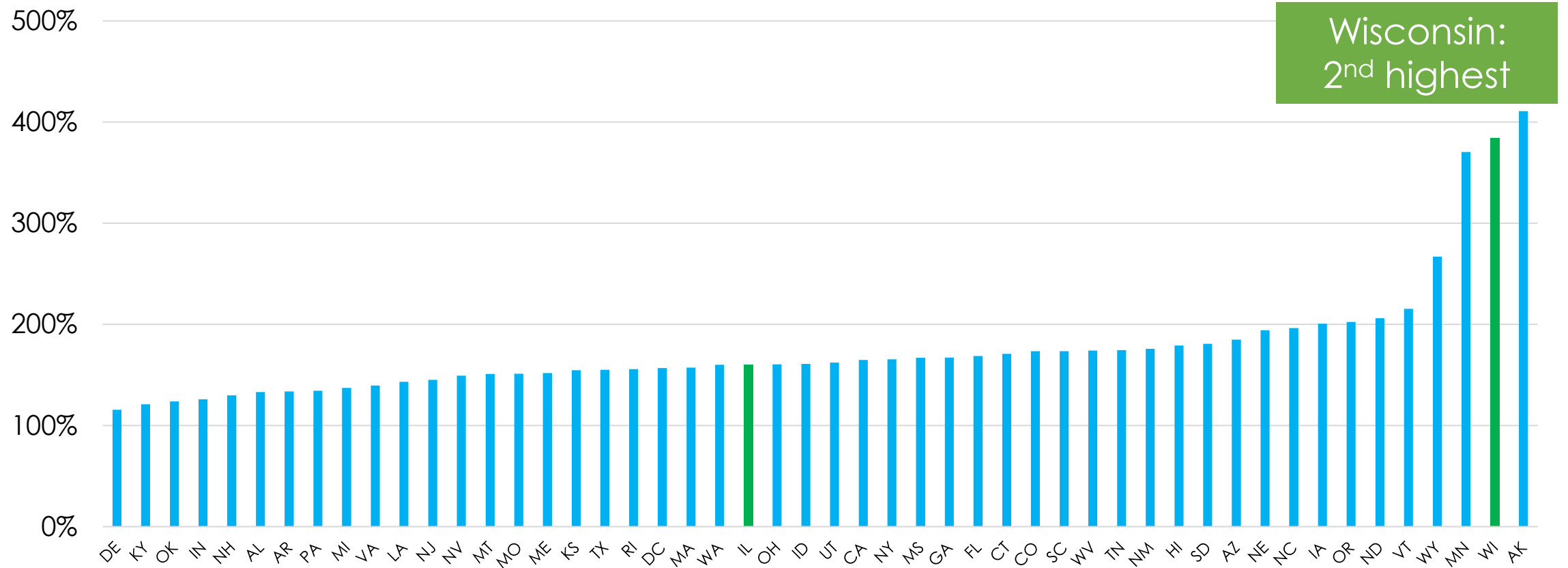
WI and IL Outpatient facility prices are middle of the pack relative to Medicare

Relative price, outpatient facility



Wisconsin professional fees are high relative to Medicare

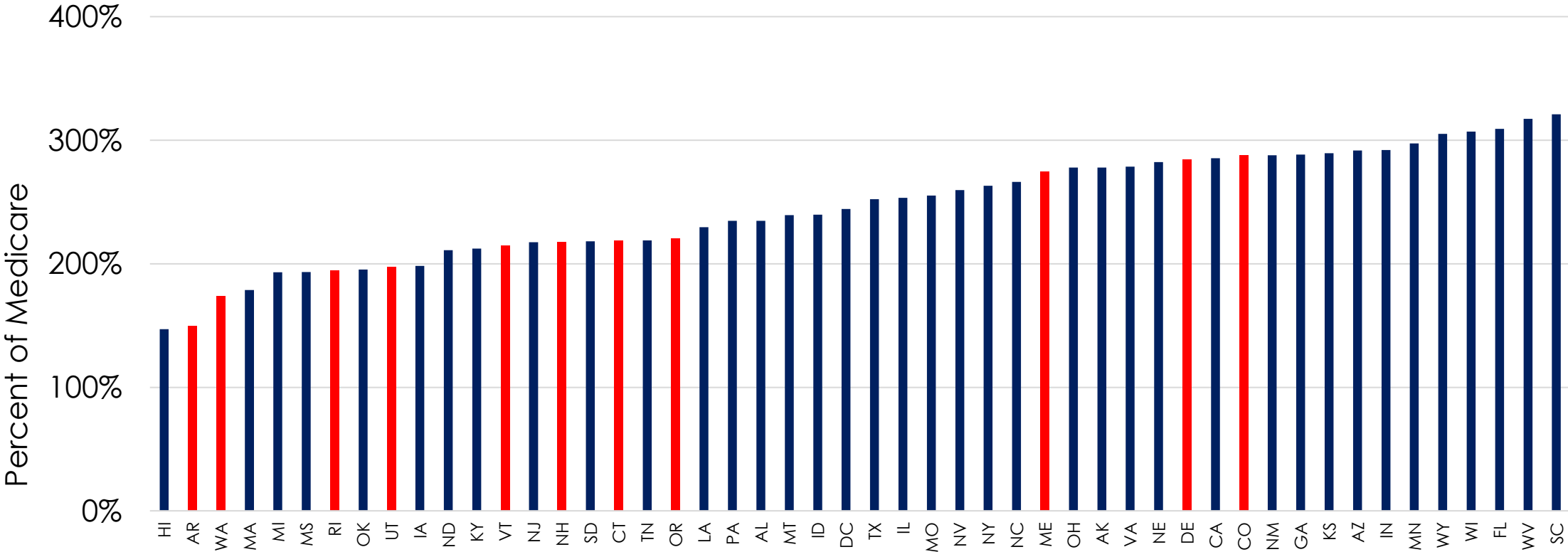
Relative price, professional



Wisconsin:
2nd highest

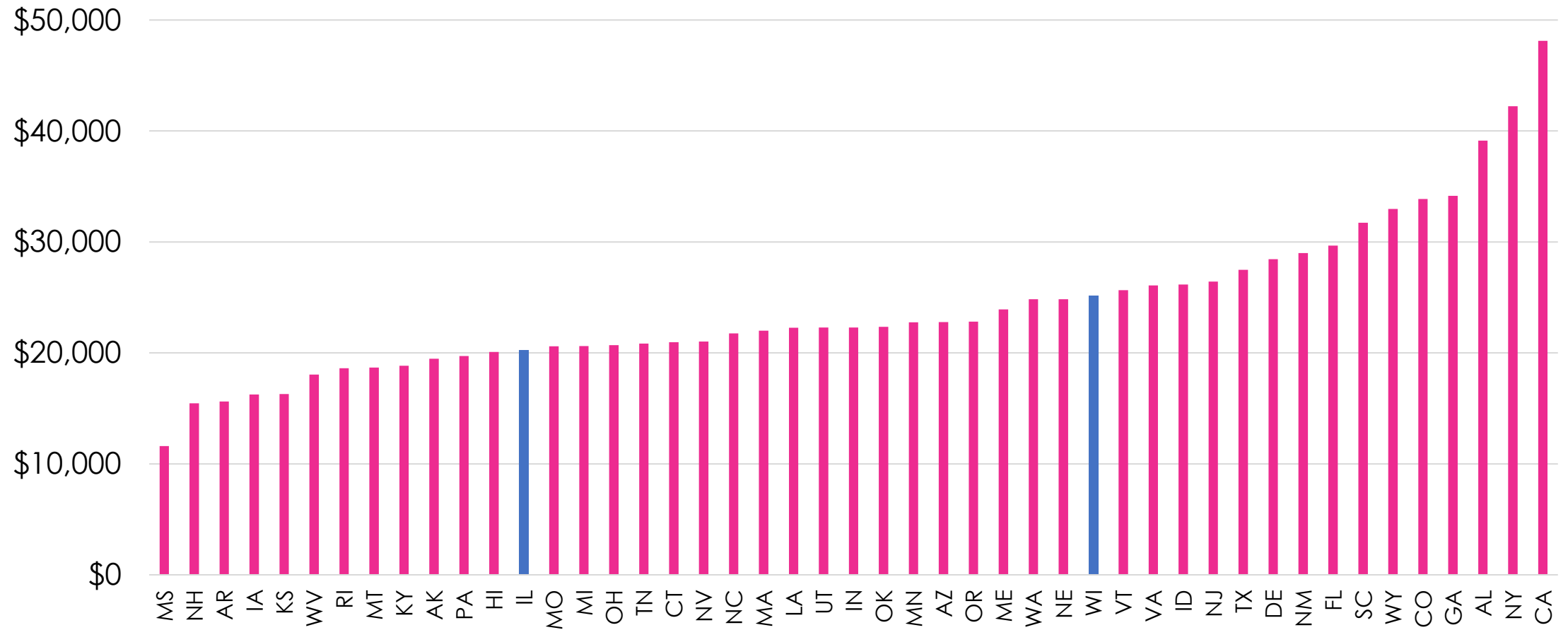
States with Contributing APCDs have lower prices

Inpatient and Outpatient Relative Price



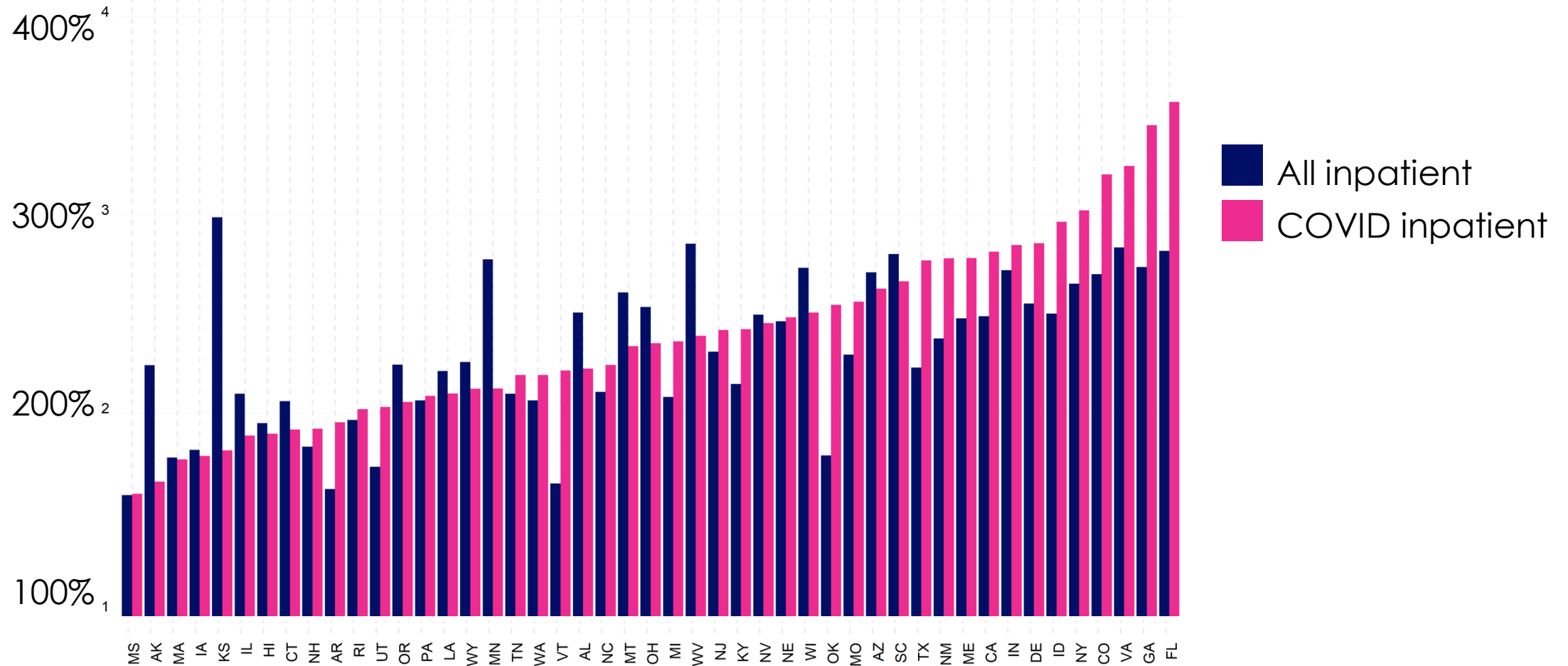
Wide range in COVID-19 hospitalization prices

Private standardized price, inpatient Covid stays



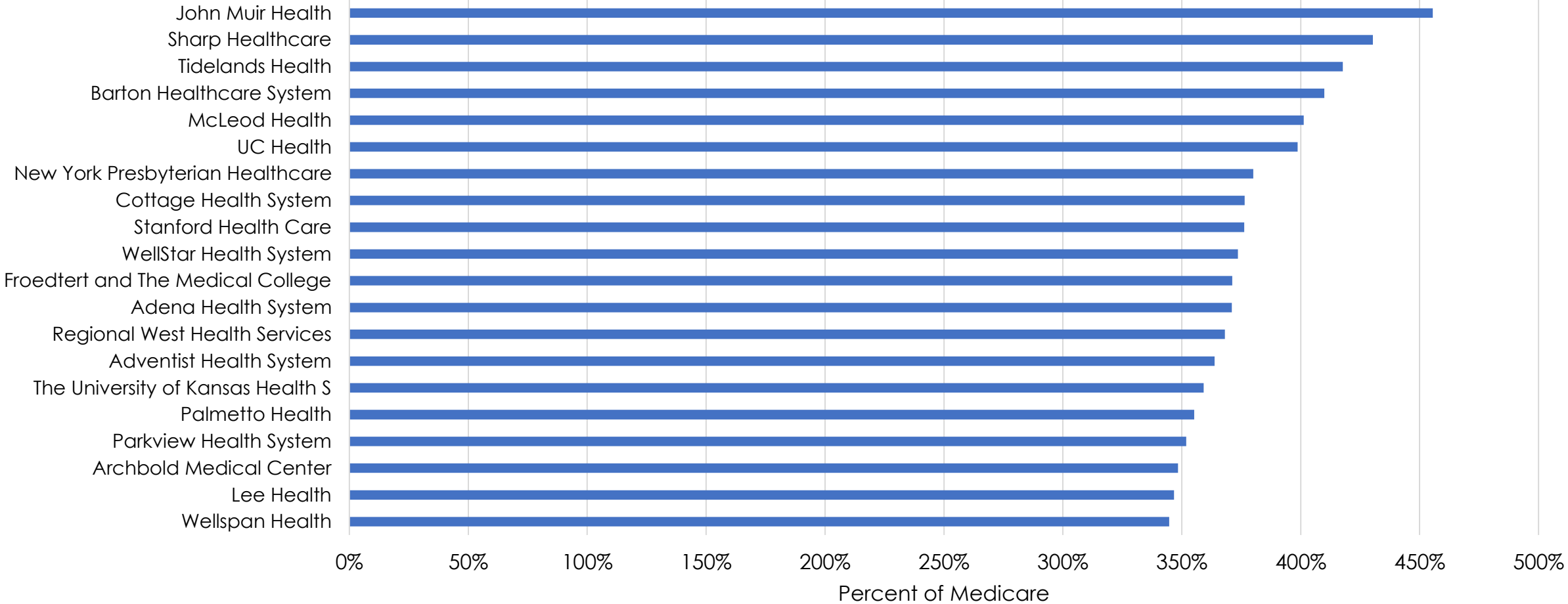
COVID hospitalizations mirrored inpatient prices

COVID inpatient care relative price ratio, commercial to Medicare



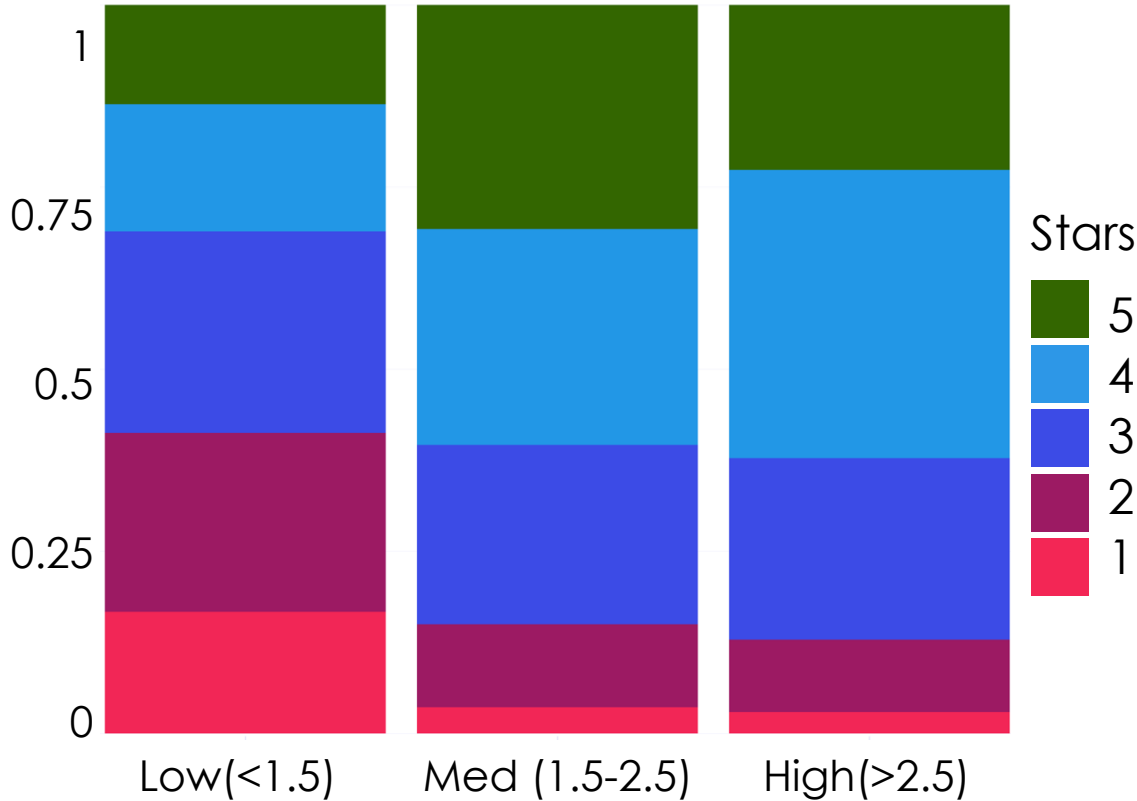
Top 20 highest-priced hospital systems

Relative price for inpatient and outpatient services



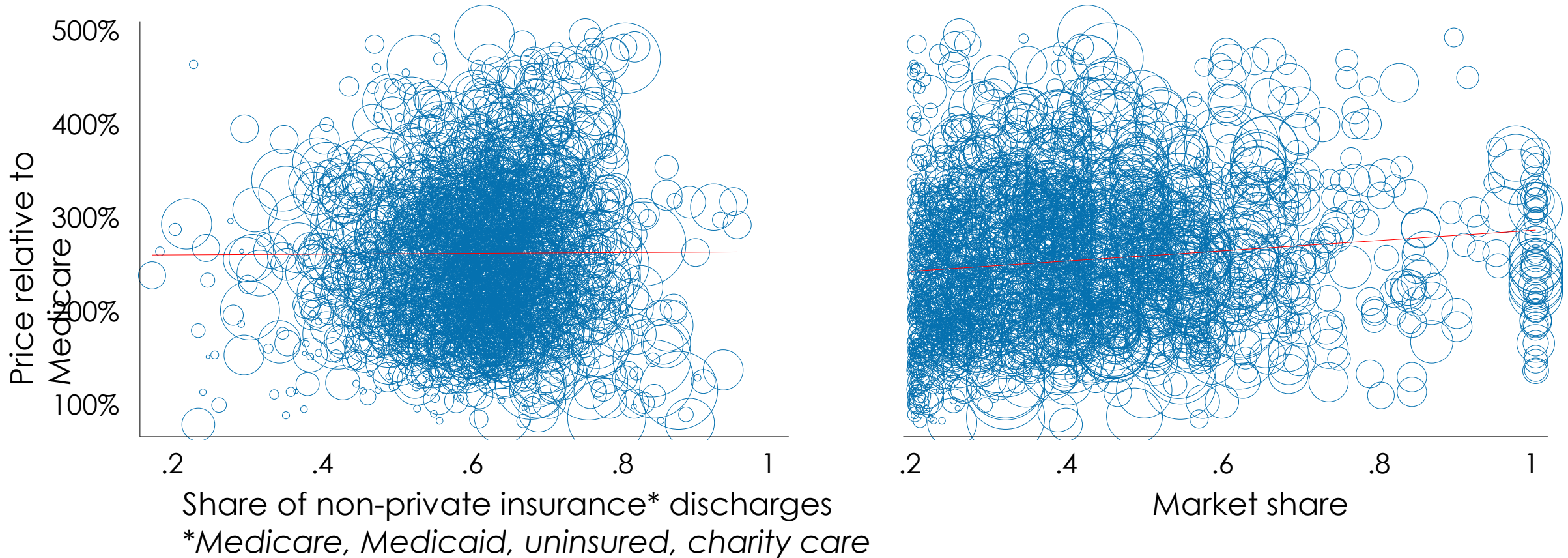
Some link between price and quality, but there are many high-quality hospitals with low prices

CMS hospital star ratings by relative price group



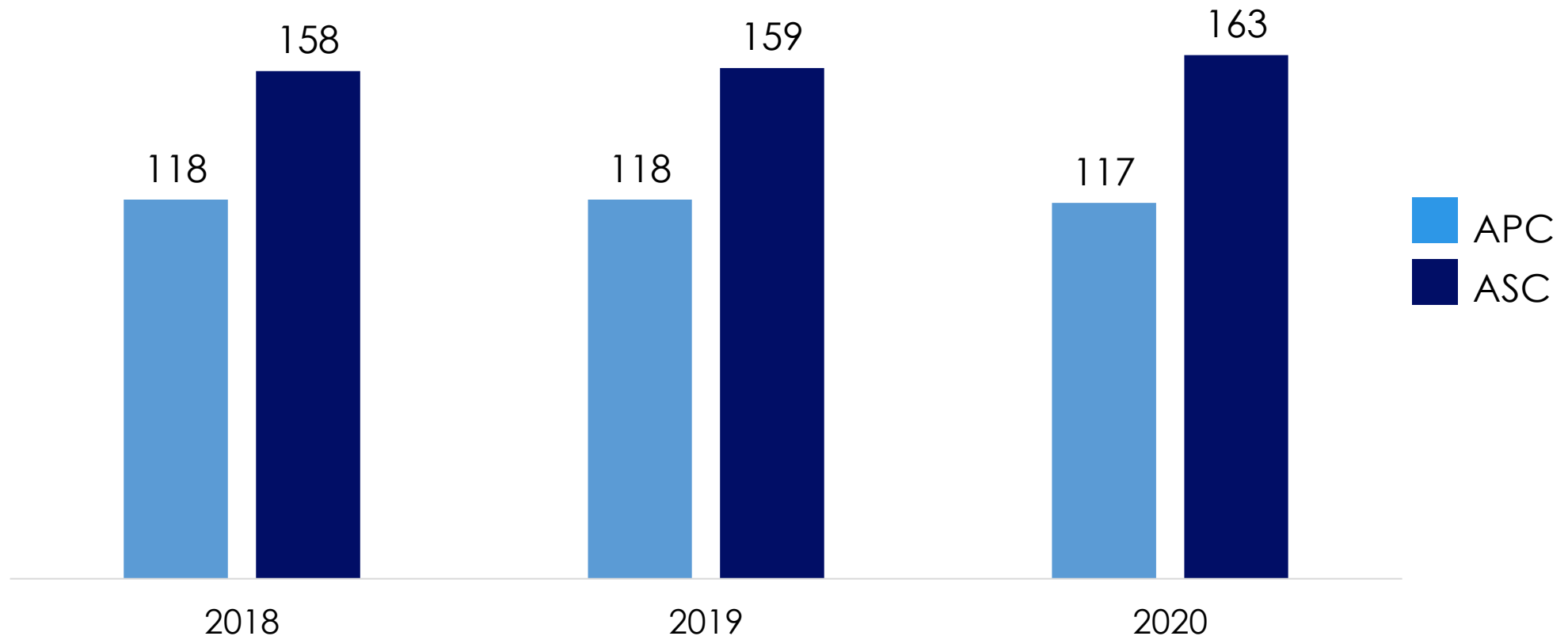
Non-private patients doesn't explain hospital prices, but market share does

Circles represent number of beds



ASC relative prices have remained stable, and lower than HOPD prices

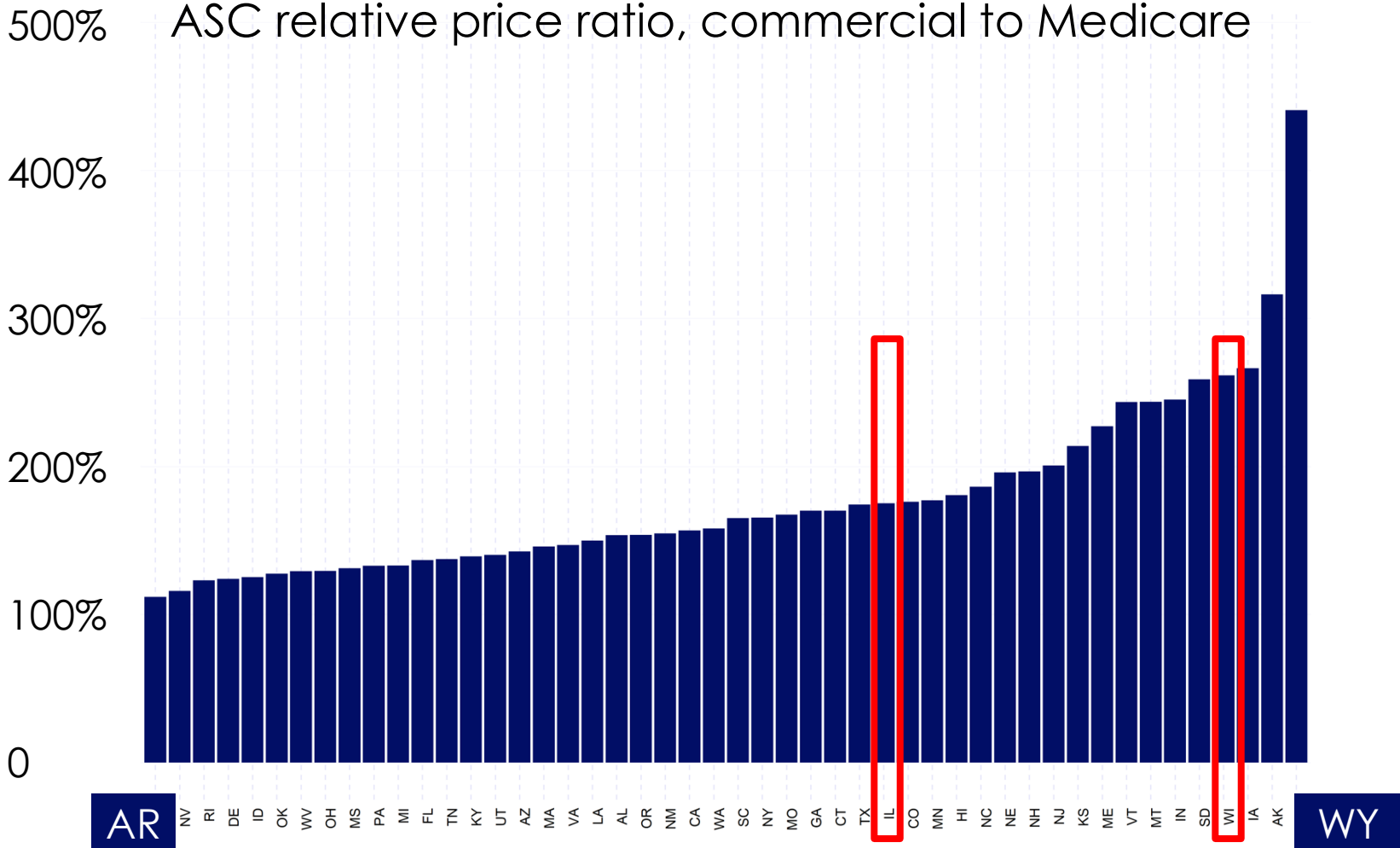
ASC relative price ratio, commercial to Medicare



ASC: Ambulatory Surgical Center

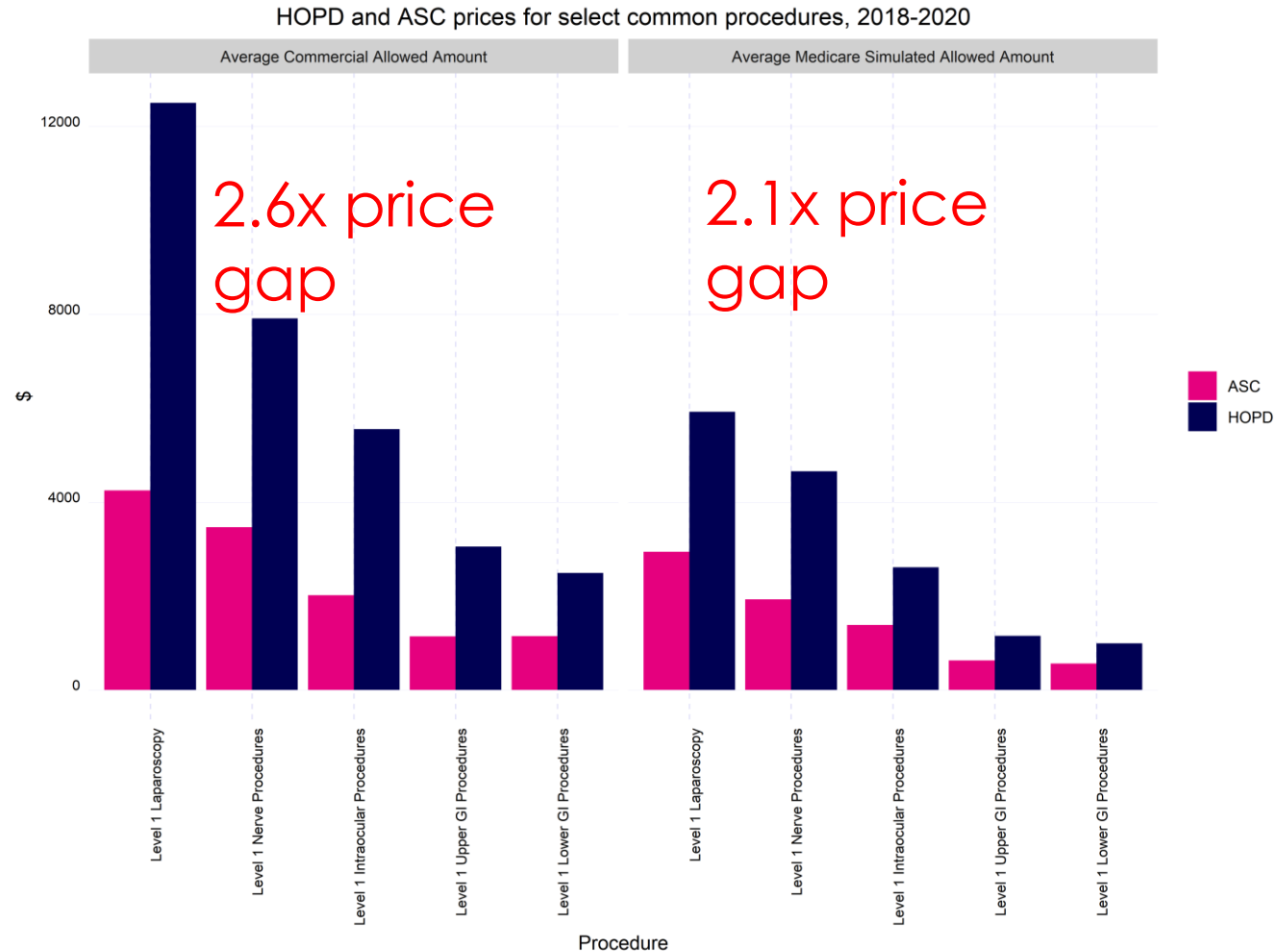
HOPD: Hospital Outpatient Department

ASC relative prices vary across states



ASCs are lower-priced than HOPDs, and price gap is larger for Commercial than Medicare

Mean prices
ASC: \$2,404
HOPD: \$6,304



How can employers and policymakers use price transparency?

Finally have
information
about prices



Benchmark
prices



Change
hospital
networks



Employers are collecting information about prices

- The Colorado Business Group on Health used RAND 2.0 data to produce a report on value of Colorado hospitals
- The report proposed options for Colorado employers to address prices in their specific markets



Employers are using data to benchmark prices

Modern Healthcare

Self-insured employers go looking for value-based deals



Hispanic via Getty Images

“

A similar RAND study commissioned by self-insured employers in Indiana spurred action...In response, 12 self-insured companies asked Anthem Blue Cross and Blue Shield to develop new health plan options.

”

And they're citing our study in their negotiations

The New York Times

Many Hospitals Charge Double or Even Triple What Medicare Would Pay



The Journal Gazette

Insurer pushes Parkview on costs

Says charges too high, citing study hospital calls unfair



Anthem is attempting to support a core goal of the RAND study by holding hospital systems accountable for their prices, which in turn will benefit our employees' mental and physical health and their financial wellness.

—Purdue Senior Director of Benefits

Conclusions



Rising health care costs place pressure on employers and worker wages—especially during the COVID-19 pandemic



The wide variation in hospital prices presents a potential savings opportunity for employers



Employers need to demand transparent information on the prices they—and their employees—are paying



Employers need to use transparency to inform benefit strategy and to advocate for policies that ensure competitive health care markets

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