

# Relative Hospital Prices:

A comparison of Medicare and Commercial prices for common hospital procedures in Oregon, 2019

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March 2022



# Executive Summary

In 2019, commercial insurance plans in Oregon paid more than Medicare for the same hospital services. Commercial plans paid a weighted average 178% of the comparable Medicare fee-for-service (FFS) rate for inpatient hospital services and 247% for outpatient hospital services.

These price disparities translate to an additional \$221 million paid by commercial insurance companies above the Medicare FFS rate for the common hospital inpatient procedures examined in this report, and an additional \$400 million paid for outpatient procedures.

If commercial prices for inpatient and outpatient hospital services were capped at twice the amount Medicare pays (200% of the Medicare FFS rate), cost savings in Oregon could be almost \$200 million per year.

High health care costs can lead to stagnant wage growth, less generous health insurance benefits, and great financial risk for individuals due to illness, as well as difficulties affording health care premiums, deductibles, and copays. Health care also takes up increasing shares of state and federal budgets, competing for funding against other valuable services such as education and infrastructure.

Prices and potential savings for specific inpatient and outpatient hospital procedures can be explored in an online dashboard.

***Click here to explore the data dashboard:***  
**2019 Relative Hospital Prices Report**



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**Suggested Citation**

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**Data Source**

Data from the Oregon All Payer All Claims database, Release 4, refreshed Q1 2021. Medicare Fee For Service 2019 data are preliminary and subject to change.

**Questions**

For questions about this report, please contact: [HealthCare.CostTarget@dhsosha.state.or.us](mailto:HealthCare.CostTarget@dhsosha.state.or.us)

# Background

According to the Oregon Health Insurance Survey, almost half (49.3%) of people in Oregon receive their health insurance from a private, employer-sponsored health care plan.<sup>1</sup>

Nationally, among those that are privately insured, hospital care accounts for 36% of all health care expenditures.<sup>2</sup>

The high costs of health care, and associated high payments made by private health plans (“commercial” insurance), can significantly impact patients. As the cost of health care grows, patient responsibility amounts such as deductibles and co-payments continue to grow as well. The average deductible for a single person in Oregon was \$1,958 in 2019 and has grown by 51% since 2013.<sup>3</sup>

Commercial insurance can absorb price increases by increasing premiums and patient responsibility amounts, while public payers such as Medicare and Medicaid are limited in their capacity to pass costs on to patients by a variety of state and federal laws. Due to these limitations, increases in health care prices can lead to public payers reducing eligibility or restricting services to try to stay within their program budget.

For many consumer goods, price can be a proxy for quality and price increases are justified by the high quality of the goods or service. However, it has been shown that often high prices of health care are not connected to better outcomes, but rather the effects of market consolidation and market power. As a recent JAMA article noted:<sup>4</sup>

*Given these issues and evidence of the effect of consolidation on prices, it is likely that many instances of high prices reflect market power as opposed to the efficient pricing of high-quality care. Significant harms arise from high, market power-driven prices at both the individual and societal levels.*

The authors noted harms to individuals including stagnant wage growth, less generous health insurance benefits, and greater financial risk due to illness. Societal harms include a larger share of state and federal budgets devoted to health care, competing for funding against other valuable services such as education and infrastructure.

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<sup>1</sup> Oregon Health Insurance Survey. Insurance coverage by type, 2019.

<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Insurance-Data.aspx>

<sup>2</sup> Centers for Medicare and Medicaid Services (2020). National Health Expenditure Data, 2019. Table 4.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData>

<sup>3</sup> Agency for Healthcare Research and Quality (2019). Medical Expenditure Panel Survey (MEPS)- Insurance Component, 2013-2019; Tables II.F.1, II.F.2, X.F.1, and X.F.2

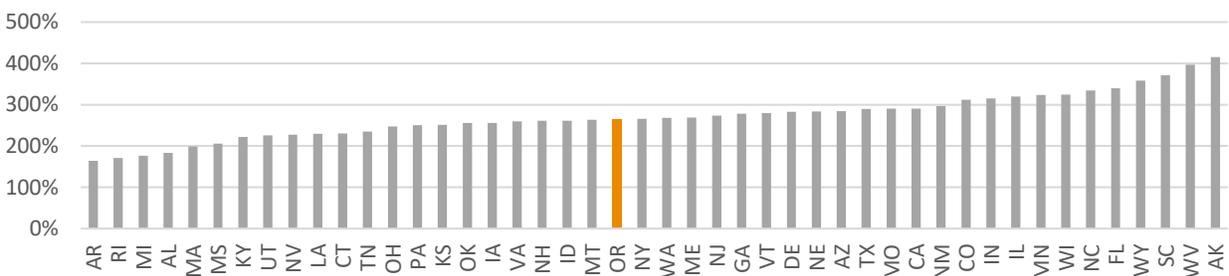
<sup>4</sup> Chernew ME, Pany MJ. (2021) Regulation of Health Care Prices: The Case for Backstop Price Caps in Commercial Health Care Markets. *JAMA*. 2021;325(9):817–818. doi:10.1001/jama.2020.26821

## Nationwide Evaluation of Health Care Prices Paid by Private Health Plans

The RAND Corporation has published a series of research papers under their Hospital Price Transparency Study examining the prices paid by private health plans for hospital services and comparing those prices to the Medicare payment amount for the same service.<sup>5</sup> The purpose of these papers is to provide price transparency and analysis using Medicare prices as a reference point. The reports analyzed hospital claims data and reported relative prices of hospital services in terms of a percentage of the average Medicare price.

In a recent iteration of this research, RAND included limited Oregon-specific data and reported relative prices of hospital services in terms of a percentage of the average Medicare price for the state. Overall, RAND reported that in 2018, commercial insurance paid 219% of Medicare prices for inpatient services and 265% of Medicare prices for outpatient services in Oregon.<sup>6</sup>

**Figure 1. RAND analysis of relative prices for outpatient services paid by commercial insurance, by state, 2018**



In a January 2022 report, the Congressional Budget Office (CBO) found that commercial insurers’ per-person spending on hospital and physician services has grown more quickly than spending by the Medicare Fee For Service program, and that the main reason for this growth is the rapid increase in the prices that commercial insurers pay for these services.<sup>7</sup>

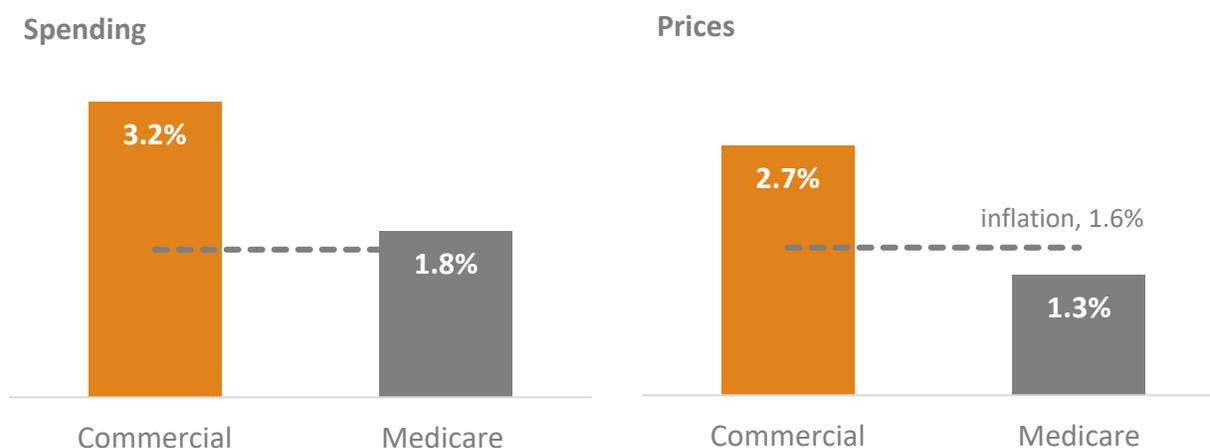
CBO found that increases in the prices that commercial insurers pay are associated with increases in premiums for employers or employees, increases in out-of-pocket costs for members, reductions in covered benefits, slowdowns in wage growth for employees, or declines in firms’ profits.

<sup>5</sup> <https://www.rand.org/health-care/projects/price-transparency/hospital-pricing.html>

<sup>6</sup> Whaley, CM, Briscoe, B, Kerber R, O’Neil BI, and Kofner A (2020) Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, [https://www.rand.org/pubs/research\\_reports/RR4394.html](https://www.rand.org/pubs/research_reports/RR4394.html)

<sup>7</sup> Congressional Budget Office (CBO) (2022). The Prices that Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services. <https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf>

**Figure 2. CBO analysis of average annual growth rates of spending and prices for hospital services, 2013 to 2018.**



From 2013 to 2018, commercial insurers’ spending per person on inpatient and outpatient hospital care and physicians’ services grew by an average of 3.2% each year. Prices rose by an average of 2.7% each year, about 1 percentage point faster than average inflation during that period (as measured by the change in the gross domestic product price index).

Per-person spending grew more slowly for the Medicare Fee For Service program than for commercial insurers during this time period, 1.8% a year on average. This spending growth also stemmed mostly from price increases, which rose by an average of 1.3% a year.

### **Building on the RAND Analysis**

Analyzing prices across markets is crucial for Oregon to achieve its health care cost containment goals put forth by the Oregon Legislature and implemented by the Health Care Cost Growth Target program.<sup>8</sup> This analysis reports metrics similar to the RAND and CBO reports but uses more complete and comprehensive data for the Oregon market to provide transparency around the relative prices paid by commercial insurance in comparison with Medicare fee-for-service rates. This report also provides more granular detail about price differences between specific inpatient and outpatient services.

We did not attempt to directly replicate the study produced by RAND, but instead leveraged existing procedure groupings and methods established for the Oregon Hospital Payment Report program to conduct a relative price analysis. See the Appendix below for key differences between the RAND analysis and the Oregon Health Authority analysis and methodology.

<sup>8</sup> <https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>

# Key Findings

In 2019, private health insurance in Oregon paid a weighted average 178% of Medicare FFS for equivalent inpatient services and a weighted average 247% for equivalent outpatient services.

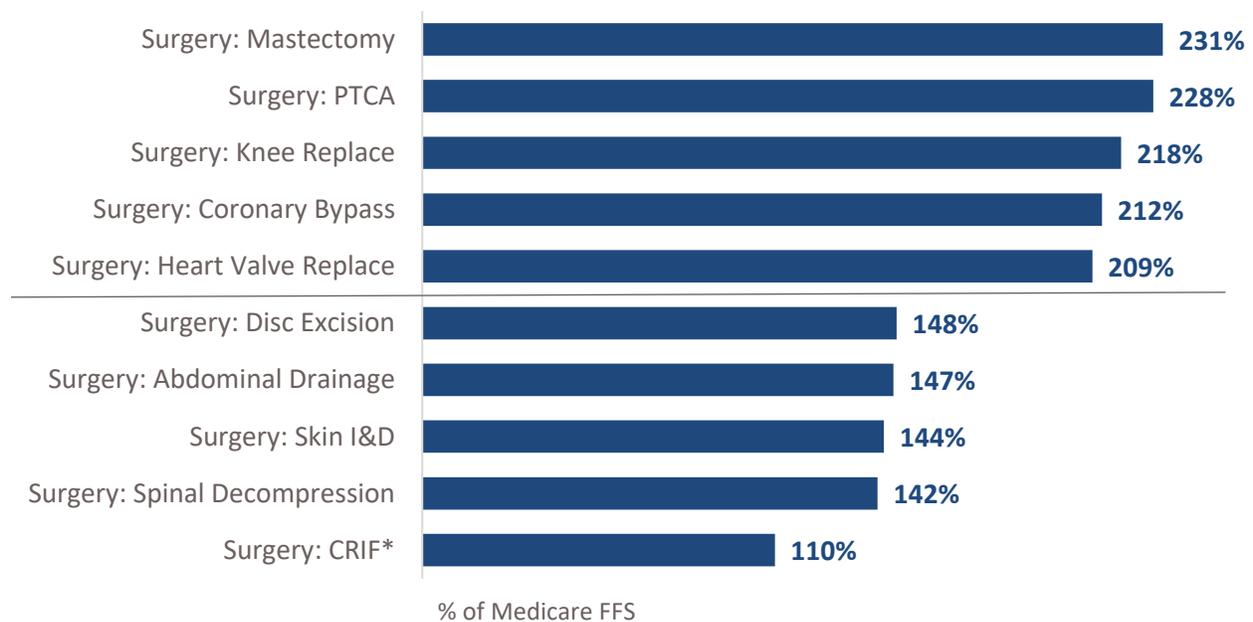
**Figure 3. Weighted average of commercial prices relative to Medicare FFS, 2019**



## Variation in relative prices for inpatient procedures

While all commercial insurance prices for hospital procedures are higher than Medicare FFS prices, the difference in prices varies by procedure. For inpatient procedures, prices range from 110% of Medicare FFS for closed reduction-internal fixation (CRIF), an orthopedic surgery, to around 230% of Medicare FFS for percutaneous transluminal coronary angioplasty (PTCA) and mastectomies. The highest and lowest priced inpatient procedures in 2019 were surgical.

**Figure 4. Top 5 highest & lowest priced inpatient procedures, relative to Medicare FFS**



\*Procedure was performed less than 30 times in the Medicare or Commercial market in 2019.

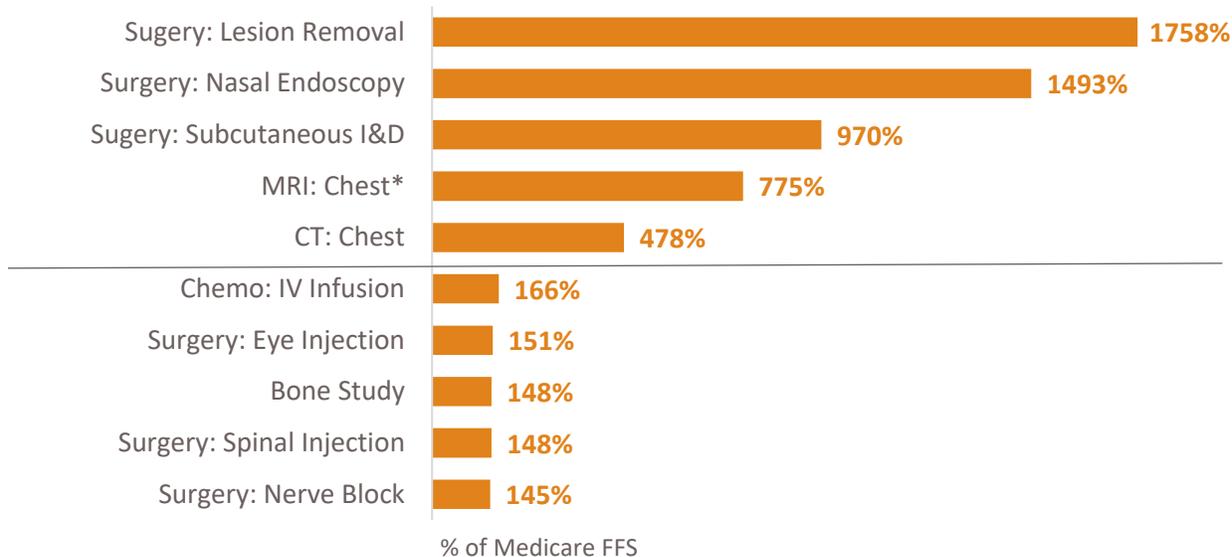
There is less overall variation between Medicare FFS and commercial prices for inpatient procedures than outpatient procedures. This is likely due to the commercial insurance industry adopting similar reimbursement strategies to Medicare by making lump payments for entire hospital stays based on MS-DRGs, rather than paying for individual components of the inpatient stay.

Variation is further limited because complex and complicated hospital admissions are isolated to the few large urban hospitals. Smaller or rural hospitals will transfer high acuity patients, ultimately reducing the overall diversity of discharges across the state.

### Variation in relative prices for outpatient procedures

The variation in relative price is much wider for outpatient procedures, ranging from 148% of Medicare FFS for surgical nerve blocks to almost 1800% of Medicare FFS for surgical lesion removal.

**Figure 5. Top 5 highest & lowest priced outpatient procedures, relative to Medicare FFS**



\*Procedure was performed less than 30 times in the Medicare or Commercial market in 2019.

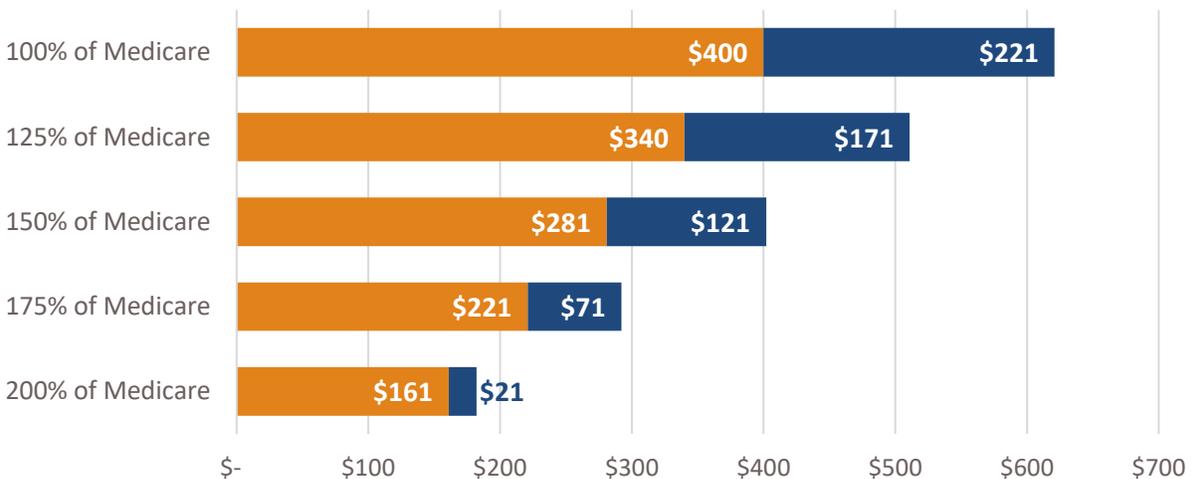
There is more variation in commercial insurance prices for outpatient services than inpatient services, because there is more variety in types of outpatient services. Outpatient services are also less concentrated in large hospitals, with most smaller hospital clinics offering a full range of outpatient services. However, smaller hospitals may not have enough utilization of some services to offset costs, leading smaller hospitals to negotiate for higher payments from commercial carriers.

## Impact on health care costs

Overall, commercial insurers paid more than double what Medicare FFS would have spent for the same hospital services. If commercial insurers had paid for every hospital service included in this analysis using the Medicare FFS rates, the total paid amount in 2019 would have been reduced by \$221 million for inpatient services and \$400 million for outpatient services. If commercial payers continued to pay more than Medicare FFS but closed the gap slightly, savings would result. Even if commercial payers had paid 200% of Medicare FFS rates for every procedure we measured, the cost savings in 2019 would still have been \$21 million for inpatient and \$161 million for outpatient services. See Figure 6 below.

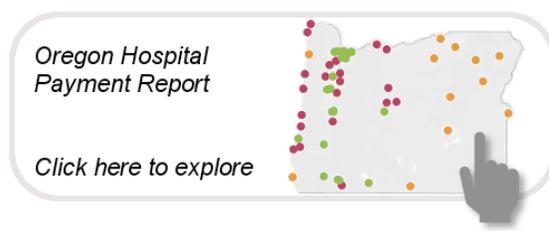
Potential savings are higher for outpatient services than inpatient services because the commercially insured population uses more outpatient services than the Medicare population.

**Figure 6. Potential savings if commercial payers had paid for inpatient and outpatient procedures at % of Medicare FFS rates instead of the commercial rates (in millions)**



## For more information

The full list of procedures and corresponding price comparisons between commercial and Medicare FFS, as well as estimates of potential savings are available in an online dashboard. More information about how commercial prices for these procedures vary by hospital across Oregon is also available in an online dashboard.



# Appendix

## Differences between the RAND and OHA analyses

**Identifying Procedures:** The RAND report identifies services by MS-DRGs or Ambulatory Payment Classifications (APCs) which are categories of services defined by the Centers for Medicare and Medicaid Services. The hospital price reporting performed by OHA also aggregates similar procedures into categories but does so at a more granular level than MS-DRG or APC. An example of the difference in categorization between the two reports is that the RAND report produces a single price for MS-DRG 470: major joint replacement of the hip or knee, whereas OHA produces separate prices for knee replacements and for hip replacements.

**Calculating Prices:** the RAND report calculates a standardized price in a way that is similar to producing an average, i.e., the total sum of payments in a given MS-DRG or APC is divided by the number of units provided. OHA does not calculate an average, but rather uses the median, or 50<sup>th</sup> percentile observation, as the service price.

## OHA Methodology

Since 2015, OHA has reported annually on the median amount paid by private insurance plans for the most common hospital inpatient and outpatient services. Using the established methodology for the Oregon Hospital Payment Report, we analyzed Oregon's All Payer All Claims (APAC) data from 2019 and derived median paid amounts for 39 inpatient procedures and 86 outpatient procedures for both the commercial insurance market and the Medicare fee for service market. Paid amounts for procedures were then weighted by frequency to create an overall weighted average paid amount for inpatient and outpatient services. The sum of the weighted paid amounts results in the overall weighted average.

Details about the underlying methodology for reporting median paid amounts and the inpatient and outpatient procedures are available online at:

<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx>

## Understanding Medicare reimbursement

It is important to understand how Medicare sets reimbursement rates when interpreting relative price information. Medicare sets rates differently depending on the type of service.

**Hospital Inpatient Services:** Medicare uses the Inpatient Prospective Payment System (IPPS). This system assigns a base payment rate to each of 761 categories —called MS-DRGs— of hospital services CMS defines. Any patient discharged from the hospital will have their service categorized as one of these predefined MS-DRGs. The base payment then has adjustments for labor costs and case mix applied, based on local geographic factors. This adjusted payment amount can be modified further by a variety of add-on payments and incentive payments

designed to either reward high quality care, or further supplement hospitals that have unusually high percentages of low-income patients.

**Hospital Outpatient Services:** Hospital outpatient services are reimbursed in a similar manner using the Outpatient Prospective Payment System (OPPS). The primary difference is the system used to categorize services. Instead of using the MS-DRG categories for base payments, outpatient services are defined as Ambulatory Payment Classifications (APCs). Like MS-DRGs, a base payment rate is adjusted for labor costs unique to the hospital's geographical region.

Medical providers and non-hospital-based clinics are paid on a different basis than hospitals, however their payments are not compared in this paper and thus are not discussed.

**Medicare Advantage reimburses differently than standard Medicare:**

A Medicare Advantage plan (or Medicare part C) is a plan that is administered by a commercial health insurance company. The company collects a monthly premium amount from CMS for each member enrolled and is then responsible for providing Medicare services to the member. The private health insurance company is then able to collect additional premium amounts from the member in order to offer expanded services from standard Medicare.

This paper only compares Medicare fee for service rates with private insurance rates and excludes Medicare Advantage payments.

## **Medicare Spending in Oregon**

Medicare reimbursement varies significantly across the United States. In 2018, CMS reported standardized total per capita Medicare spending in the US that ranged from a low of \$7,000 in Hawaii to a high of nearly \$12,000 in Louisiana.<sup>9</sup> At \$7,800 in 2018, Oregon is on the lower end of per capita total Medicare spending. This is due to the large number of ways the base reimbursement amount to a hospital can be modified. As noted above, base rates are modified by unique hospital factors. In addition to labor cost and case mix, CMS will increase payments to facilities that meet certain quality metrics and decrease payments to facilities that fail to meet those metrics.

Total Medicare spending is also influenced by the characteristics of the enrollment in the state.<sup>10</sup> In Oregon, there is a lower-than-average number of disability-eligible Medicare enrollees, meaning Oregon has fewer Medicare members receiving benefits based on disability status rather than age compared with national averages. Additionally, Oregon has a higher-than-average Medicare Advantage enrollment percentage. As of 2019, 43% of all Medicare beneficiaries in Oregon are enrolled in a Medicare Advantage plan.

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<sup>9</sup> Centers for Medicare and Medicaid Services (2020) Geographic Variation in Standardized Medicare Spending. Interactive web interface accessed 3/12/2021 available at: <https://portal.cms.gov/portal>

<sup>10</sup> Kaiser Family Foundation (2021) State health facts. Interactive web interface accessed 3/12/2021 available at: <https://www.kff.org/statedata/>