

## Executive Summary

### **The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured**

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Health care is one of the largest sectors of the U.S. economy and accounted for 17.4 percent of gross domestic product in 2013. Most individuals in the US (60 percent) receive their health coverage from private insurers. However, because of data availability, most of the analysis of health care spending in the U.S. has relied on data from the Medicare program, which only covers 16 percent of the population. In this paper, we use a newly released, large health insurance claims database that covers almost a third of all individuals with employer-sponsored insurance coverage to study the variation in total and inpatient health spending for the privately insured. This gives us the most detailed view to date of how health spending for the privately insured varies across the U.S. From there, we focus on how the prices of health care services influence spending levels across the nation and then examine how and why hospitals' prices vary within and across markets. A secondary focus of this paper is examining the extent to which conclusions about health spending that are derived from the analysis of Medicare data generalize to patterns we observe for the privately insured.

The data we use in this analysis offers us the most comprehensive and detailed view to date of U.S. health spending for the privately insured and health care providers' negotiated prices. The data includes claims for individuals with employer-sponsored insurance from Aetna, Humana, and UnitedHealth from 2007 through 2011. The data, which comes from the Health Care Cost Institute (HCCI), contain detailed information on approximately 5 percent of total health spending and nearly 1 percent of GDP annually. Historically, there has been very little data on the prices health care providers negotiate with private insurers. Crucially, our data include the prices that private insurers negotiate with health care providers and we have coverage and capture provider prices in all 306 Hospital Referral Regions (HRRs) in the U.S.

Our work highlights that the factors that drive spending variation for the privately insured – notably the price of health care services - differ substantially from the factors that have been found to drive spending variation in the Medicare program. Ultimately, we point to four conclusions from our work.

First, health spending per beneficiary varies by a factor of three across Hospital Referral Regions. In 2011, the lowest spending area (Honolulu, Hawaii) spent \$1707.39 per privately insured beneficiary, whereas spending per beneficiary in Napa, California, was \$5515.90 per person. Moreover, Private and Medicare spending per beneficiary are not highly correlated. In 2011, the correlation between Hospital Referral Region-level total spending per Medicare beneficiary and total spending per privately insured beneficiary is 0.14. The correlation is slightly higher for inpatient spending, 0.267, but still not large.



To illustrate the point, policy makers have identified Grand Junction, Colorado, as an exemplar of health sector efficiency based on analyses of Medicare data. We find that, in 2011, Grand Junction does indeed have the third lowest spending per Medicare beneficiary among Hospital Referral Regions. However, in 2011, Grand Junction has the 9<sup>th</sup> *highest* average inpatient prices in the nation and the 43<sup>rd</sup> *highest* spending per privately insured beneficiary of the nation's 306 Hospital Referral Regions. Likewise, other regions that have received attention from policy-makers on the basis of their Medicare spending, like Rochester, Minnesota, and La Crosse, Wisconsin, also have high spending on the privately insured.

Second, for the privately insured, hospital transaction prices play a large role driving inpatient spending variation across Hospital Referral Regions. In contrast, prices play a very small role driving spending variation for Medicare beneficiaries. Virtually of the variation in Medicare spending is driven by differences in the quantity of health care across regions.

Together, these two facts strongly imply that policy-makers must be cautious generalizing recommendations about addressing health spending that flow from the analysis of Medicare data to address health care spending for the privately insured.

Third, we find that hospitals' negotiated transaction prices vary substantially across geographic areas. Prices for routine services often vary by a factor of more than ten across Hospital Referral Regions. We also observe striking variation in provider prices within Hospital Referral Regions. Indeed, for our least differentiated service, hospital-based MRIs of lower limb joints, hospital prices vary by a factor of 5.94 in Philadelphia, Pennsylvania in 2011 and by a factor of twelve across the U.S.

Finally, we describe some of the factors associated with hospitals having high prices. Being for-profit, having more medical technologies, and having a low share of Medicare patients are all associated with higher prices. But even after controlling for these factors plus other controls for costs and quality, we find that hospitals in monopoly markets have prices that are 15.3 percent higher than providers in markets with four or more hospitals. While we cannot infer causality, these associations do suggest that, consistent with economic theory, hospital market concentration is strongly related to hospital prices.

In terms of policy, our work suggests that antitrust enforcement is crucial to addressing health care providers' prices. Moreover, our work suggests that hospital prices should be made more transparent. More information, such as recent efforts in Massachusetts to make hospitals' prices public, could help patients and their physicians make more informed choices over treatment and put downward price pressure on more expensive hospitals in a sector of the economy where consumers (patients) presently know almost nothing about what they or their insurer will pay for care.