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New price transparency data reveals tremendous variation in rates by county

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<https://www.chartis.com/insights/new-price-transparency-data-reveals-tremendous-variation-rates-county>

The Buzz This Week

Private health insurance pricing is highly variable by state, according to a [recent Research Letter](#) published in the Journal of the American Medical Association (JAMA) Health Forum. While this analysis aligns with previously published studies, the more granular level of data now available through the new price transparency rules makes this one of the first studies to examine geographic variation at the county level.

Previous research has shown that private insurance plans generally pay providers more than federally sponsored plans, such as Medicare. A 2020 Kaiser Family Foundation (KFF) [literature review](#) found that, on average, private insurers paid nearly twice the Medicare rate for hospital care, and more than 250% the amount for outpatient services. A series of [RAND studies](#), based on data from 2015 through 2020, similarly demonstrated the average private plan paid 225% to 250% more than Medicare. Since negotiated rates between private plans and providers have been kept highly confidential until recently, it was difficult for employers and consumers to evaluate and compare pricing and value. States also have different policies in place related to pricing, adding to the complexity and variability across the nation. For example, according to the aforementioned KFF review, Colorado and Nevada plan to enact [pricing rules](#) to set payments at a percentage of Medicare rates. Maryland and Vermont have implemented “all-payer” programs, in which their state-set payment rates for all hospitals (Maryland) and accountable care organizations (Vermont) do not tie provider payments to an explicit percentage of Medicare rates. This has “achieved savings on state-level health expenditures by some measures.”

One might think that recent price transparency rules would encourage more consistent pricing across providers, especially in states with all-payer models. However, the recent JAMA analysis showed a high degree of variation by county in many states, and sometimes counties with the highest average private insurer payments were directly adjacent to counties with the lowest average pricing. The study focused on 7 procedures covered by Humana, a company chosen due to its broad national coverage of physicians and

facilities. Results showed that payments for high-acuity Emergency Department (ED) visits ranged from \$169 to \$320, with a ratio of 25th to 75th percentile of 1.89. The study provides a map and table of the full data findings.

Why It Matters

The main goals of the JAMA research were to explore possible key drivers of healthcare price variation and show that newly available data can help inform state policies that create a more level field in healthcare pricing among private insurers, potentially incenting higher efficiency and better cost management in the healthcare delivery system. The authors note that price variation could be driven by the actual or perceived value of care delivered (value being defined here as quality over cost). The other possible driver could be differences in negotiation leverage across payers and providers. According to the authors, the “factors determining price variation are likely in the middle of these 2 possibilities.” They also explained that future work involving a larger number of insurers, and examining more procedures, will be needed to arrive at a stronger conclusion on the key drivers of healthcare price variation by market.

If indeed driving forces, either of these 2 factors can inform rules, regulations, and price negotiation for insurers and policymakers. For example, if pricing reflects real—or perceived—clinical quality variation, policymakers can shape pricing rules, and payers can negotiate pricing with providers based on the value of care. If market consolidation, and even anti-competitive market dynamics, have set an imbalance in negotiating power (tipped toward either insurers or healthcare providers), policymakers should consider adopting rules to support more competition in their states. Additional research would be germane to the push toward healthcare consumerism, as nearly two-thirds of Americans have health insurance through private insurers.

Finally, an analysis like the JAMA study requires massive amounts of data and high-caliber computing capabilities. Most consumers and employers do not have the resources or expertise to perform such analyses. Despite new price transparency rules, the system is still highly opaque to most non-academics, limiting healthcare consumerism with a lack of “shoppable” data. Progress is being made, however, with additional requirements added to price transparency rules in January 2023, and final state rules being enacted in January 2024. These rules would allow third parties, researchers, and application developers/analytic platform companies to help consumers better understand the costs and pricing for their healthcare.

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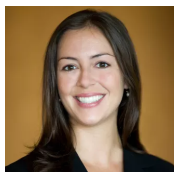
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