Medicare versus Commercial Health Insurance Payment Disparity

Abstract

Working age people pay more for health care than those on Medicare. Commercial health insurance is more expensive than Medicare insurance due to the fact that health insurance companies pay medical providers more for the same care than Medicare. Just how much pricing variation exists by both payer and provider type has been lacking transparency.

This pricing disparity does not exist in any other sector of our economy. We can purchase the same item at the same price, whether it is online via Amazon or in a retail store like Walmart, except for healthcare. With medical cost transparency, it is believed that the same result with same and better pricing will occur. This is referred to as capitalism.

The purpose of this study was to determine the pricing disparity between Medicare and commercial insurance payments for the same care by medical provider type, such as hospitals, freestanding ambulatory surgery centers, imaging centers and blood work centers.

By understanding price points and ratios for payment of care by health insurance companies to Medicare, employers and employees can better negotiate what they pay for care and best determine where they can go to receive more affordable access to care.

Conclusion: The federal government does not discriminate when it comes to payment for the same care item across different medical provider types, such as hospitals, surgery centers and blood work centers. Payments are similar. Medicare payments were typically much less than health insurance payments per care item.

Health insurance companies paid more for blood work at 500%, MRIs/CTs at about 270% and common gastroenterology (GI) scopes at about 30% more than Medicare.

By provider type, health insurance companies disproportionately paid hospitals more than Medicare, making hospitals the most expensive place to receive medical care. Health insurance company payments to hospitals revealed average price differences for blood work at 795%, MRIs/CTs at about 470% and common gastroenterology (GI) scopes at about 200% of Medicare payment amounts.

Non-hospital Medicare to health insurance company payments to non-hospital facilities revealed average price differences for blood work at 240% MRIs/CTs and at about 186%. Again, health

insurance companies paid more for the same care. However, for common gastroenterology (GI) scopes, Medicare paid 6% more than health insurance companies, suggesting freestanding surgery centers are the best value for care, and likely undercompensated in the commercial insurance market.

By establishing a ratio of health insurance company payment to Medicare payment, all purchasers of health care can better target a Medicare fee schedule or closer to it. By doing so, both the price tag per care item and pricing variation per care item are reduced to save money and create affordable access to medical care.

Introduction

Every year employers are paying more for healthcare blindly, having never received an itemized medical bill before or after it has been paid. The cost shift burden to employees is unsustainable, as they pay blindly for care also. Employees have little say as how to lower their employer-sponsored health plan cost and employers have not had the health plan insight to create effective, sustainable cost savings solutions.

All are seeking known pricing with a general understanding that health insurance company discounts off a charge master retail rate, known as a "top down" approach, has not resulted in savings but instead a greater healthcare spend every year. There is an emerging business strategy to take a "bottom up" approach to health are pricing called Medicare reference-based pricing (RBP) to save medical money. By reducing both the price and pricing variability per car item, savings would be achieved.

Health plan costs have risen substantially yet salaries have remained nearly flat, up only 15% over 20 years. At the beginning of every year, working America is demoted as healthcare costs unsustainably rise more than salaries (Figure 1).

In 2015, the Kaiser Family Foundation found that medical bills made one million adults declare bankruptcy. Its survey found that 26 percent of Americans age 18 to 64 struggled to pay medical bills. According to the U.S. Census, that represents 52 million adults.

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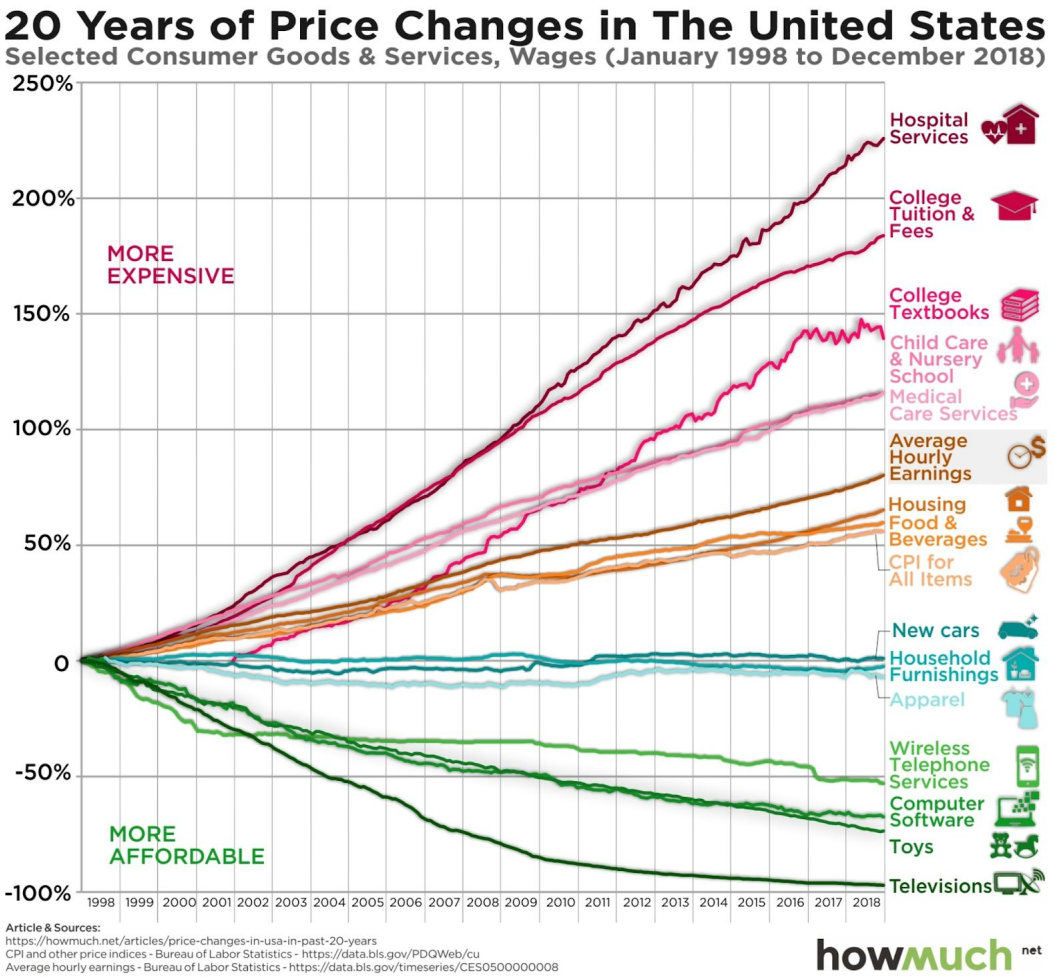
Figure 1. Unsustainable health care costs versus average hourly wages.



Problem Defined

Employers and unions experience unsustainable increases in healthcare costs each and every year without an explanation. Most importantly, they have been powerless to deal with these skyrocketing healthcare costs. Health plan self-funding represents a conscious decision to undertake risk for financial reward. This financial risk cannot be managed without an awareness of pricing and the need for solutions with viable outcomes.

Each health care item has four prices including the charge (retail), insurance company discount (i.e., the claim allowable amount), cash and Medicare. These are listed in price from highest to lowest. If a medical provider does business with the federal government, the cash price must be higher than the Medicare price. The government must get the best deal when it comes to utilization of taxpayer dollar, or else it is fraud. This has led to the advent of a "Medicare plus" reference-based pricing, commonly at 130% of Medicare for fee for payment services. Similarly, employers and employees as consumers of

care can use a known Medicare price to negotiate up off the bottom price to secure direct provider contracted rates as the employer or settle a surprise medical bill for less in the case of the employee.

Purpose

The purpose of performing this study was to determine if Medicare paid different types of medical providers differently and what they paid medical providers by medical provider name, medical test name and the claim allowable, also known as the real price paid, and compare these payments to commercial insurance payments.

The purpose of this study was also to determine the ratio of commercial insurance payment to Medicare payment for the same care. Medicare payments for service were also published on our search care engine on pratter.us by test name and zip code search.

Lastly, in our economy, the cost of goods and services sold is known before the time of service, except for health care. By publishing real pricing for care hundreds of millions of claims and for over 6,000 current procedural terminology (CPT) codes, we sought to determine the real interest level for viewing and leveraging known prices for medical care. Known pricing creates smart shopping. Known pricing creates competition and with competition the consumer wins every time with lower prices.

Methodology

A contract was secured with Centers for Medicare and Medicaid Services (CMS), stating the purpose for the use of the HIPAA privacy compliant, de-identified medical claims limited data set (LDS). The claims cost data was placed through a 60 step proprietary process on our secure server, isolating the medical facility fees (eg, hospital or surgery center) from the professional (doctor) fees per CPT code. The types of medical facilities that provided care were also separated by the average cost per care item by the type of medical facility. In each case, the actual price paid for care, known as the claim allowable, was used to calculate results. The charge master retail pricing was not used to provide the results of this research.

The above methodology was applied to the Medicare data and also to health insurance company de-identified claims data sets we have collected nationwide. This permitted a side-by-side comparison of Medicare to commercial health insurance company payments per CPT-coded care item.

Results

Medicare payments were typically much less than health insurance payments per care item. Medicare compared to health insurance company payments revealed average price differences for blood work at 500% price, MRIs/CTs at about 270% and common gastroenterology (GI) scopes at about 30%.

Figure 2. Claim allowable medical facility fees for common care.

Medical Test Name	CPT Code	Average Medicare	Average Insurance

		Payment	Company Payment
Comp Metabolic Panel	80053	$12	$68
Comp Blood Cell Count	85027	$9	$42
Lumbar Spine MRI	72148	$297	$872
Abdominal & Pelvic CT	74176	$250	$615
Upper GI Scope (EGD)	43235	$609	$849
Colonoscopy	45378	$735	$897

The federal government does not discriminate when it comes to payment for the same care item across different medical provider types, such as hospitals, surgery centers and blood work centers. Payments were similar. Health insurance companies disproportionately paid hospitals more than Medicare, making hospitals the most expensive place to receive medical care. See Figure 3.

Figure 3. Claim allowable medical facility fees for hospitals and non-hospitals for Medicare and health insurance companies.

Medical Test Name	CPT Code	Avg Medicare Hospital	Avg Medicare Non-Hospital	Avg Insurance Co Hospital Payment	Avg Insurance Co Non-Hospital Payment
Comp Metabolic Panel	80053	$12	$12	$124	$33
Comp Blood Cell Count	85027	$9	$9	$43	$17
Lumbar Spine MRI	72148	$301	$292	$1,331	$661
Abdominal & Pelvic CT	74176	$256	$245	$1,297	$338
Upper GI Scope (EGD)	43235	$623	$587	$1,333	$564
Colonoscopy	45378	$751	$714	$1,515	$661

Medicare to health insurance company payments to hospitals revealed average price differences for blood work at 795%, MRIs/CTs at about 470% and common gastroenterology (GI) scopes at about 200%. In all cases, health insurance companies paid the hospitals more. Non-hospital Medicare to health insurance company payments to non-hospital facilities revealed average price differences for blood work at 240% and MRIs/CTs at about 186%. Again, health insurance companies paid more for the same care. However, for common gastroenterology (GI) scopes, Medicare paid 6% more than health insurance companies. See Figure 4.

Figure 4. Health insurance company multiple of Medicare paid for hospital and non-hospital care.

Medical Provider Type	Percent of Medicare Payment for Hospitals	Percent of Medicare Payment for Non-Hospitals
Blood Work	795%	240%
Imaging	470%	186%
Surgery Center	200%	-6%

Discussion and Benefit

Medicare payment amounts per CPT-coded medical care item are published on pratter.us and searchable by medical test name and zip code. This information is valuable for gaining access to affordable care in many ways. See Figure 5. This provides any organization or individual a gold stand low price point for care from our nation's largest health care insurer. This can be used to help pre-negotiate price for common care for organizations that wish to direct provider contract. It can be used for individual to pre-negotiate a cash payment for care or to help negotiate a settlement for a surprise medical bill. This medical facility-specific pricing can be used in arbitrations and court cases as a standard payment to help settle claims disputes.

This Medicare pricing ratio helped determine that hospitals get paid significantly more by commercial health insurance companies. By using hospitals for infirmary care, and all other medical provider types, such as surgery centers, blood work centers and imaging centers, significant monies can be saved, enhancing access to affordable care. This study also proved that "discounts" off of charge master pricing overall remain with significantly higher price tags for care when compared to Medicare pricing.

Medicare reference-based pricing plans (RBP) are growing in popularity as the need to save money, remain a viable business and serve as an ERISA health benefit fiduciary become fulfilled. Associations can leverage both group purchasing power and Medicare RBP to help the 80% of America that is one to 49 employees in number, gain affordable access to care.

Figure 5. Uses of Medicare Medical Cost Transparency

1. Reduce the maximum financial risk to the health care consumer, by publishing the charge master rate
2. Use of care search engine to determine better-priced medical providers and their claim allowable real prices paid
3. Pre-negotiate a cash payment for care
4. Post-negotiate a settlement on a surprise medical bill
5. Direct provider contracting by organizations
6. Medicare reference-based pricing health plans

With enough known pricing by specific medical provider name, medical test name and real prices paid per CPT care item, the word "Medicare" will fade from "Medicare reference-base pricing." Common commodity care items performed at a high frequency will have prices set closer to the Medicare rate. Less common, more specialty-oriented care performed by a limited number of physicians at a limited number of medical facilities will be priced much higher than the Medicare rate. This is call supply and demand and represents the future of capitalism in healthcare.

Summary

All can gain affordable access to care by understanding Medicare and commercial insurance payments across different medical provider types, including hospitals, surgery centers, imaging centers and blood work centers. Known pricing creates many opportunities to save money on medical care, including capitalism, which will further lead to more medical cost savings. This research, entitled Pratter Price Tags, was conducted in compliance with Pratter, Inc.'s de-identified claims data agreement with CMS.

Call to Action

Email Mark Robinson mark.robinson@pratter.us to activate a Medicare reference-based pricing (RBP) health plan solution for your organization.

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