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High Hospital Prices and Margins in Delaware Call for Action

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High prices for hospital services lead to many people foregoing or delaying necessary health care. There remains substantial variation in hospital service prices, with some regions having much higher prices despite the fact that higher prices are not associated with better quality. For individuals with health insurance through their employer, prices are set as a function of negotiations between their insurer and local providers. Thus, high prices are often found in markets where hospitals wield significant market power and can use this leverage to charge higher rates to private insurers. In contrast, prices in public insurance – Medicare and Medicaid – are set administratively to reflect the resources needed to provide specific services in specific markets (e.g., these prices are adjusted for higher wages in some areas).

Rising prices in employee health plans threaten the affordability of health care, may hold down wages and, in the case of state employees, may have adverse consequences for the financial health of the state. Lowering prices would facilitate access to health care services by Delaware consumers, though there is understandable concern about the effect that any decrease in prices paid by private insurers could have on hospitals in the state. In this commentary, we present evidence on how hospital prices paid by private insurers in Delaware compare to Delaware's neighboring states and to Medicare and on the State's hospitals' financial status.

We used data from the MarketScan Commercial Claims database,[1] which includes private-sector health data from approximately 350 payers across the country, to measure commercial health care prices for a set of common inpatient procedures and for an inpatient "basket" of services (representing the 15 highest-volume inpatient procedures, which account for 46 percent of total admissions and 37 percent of total spending). We compared these prices to prices for the same services in Medicare using a 20 percent sample of Medicare claims. We also compared prices to prices in neighboring states (Table 1).

Table 1. Average Private Prices in Delaware relative to Medicare and Neighboring States, 2017[1]

	DE Private Price ($)	**DE Medicare Price ($)**	**Ratio of DE Private: Medicare Price**	**PA Private Price ($)**	**Ratio of PA Private: Medicare Price**	**MD Private Price ($)**	**Ratio of MD Private: Medicare Price**
Inpatient Basket with deliveries	9,067.95	3,764.56	2.41	7,778.03	1.91	7,124.76	1.35
Inpatient Basket without deliveries	5,891.10	2,629.41	2.24	4,944.29	1.90	4,329.12	1.30
Hip/Knee Replacement	35,616.20	14,448.37	2.47	27,793.94	1.98	25,689.16	1.32

We found that the mean payment for the inpatient basket for a patient with private insurance in Delaware was $9,068 in 2017, compared to $3,765 for a Medicare beneficiary in the state. As an example of the price for a specific, common procedure, the mean private price of a major joint replacement (hip or knee) was $35,616 compared to $14,448 in Medicare. Our main inpatient

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basket, described above, includes childbirth/deliveries, which may result in small sample sizes in our Medicare data since Medicare does not pay for many births. Thus, we also calculate the price of an alternative inpatient "basket," which does not include deliveries. The private and Medicare prices for this basket are lower, $5,891 and $2,629 respectively, however the ratio of private-to-Medicare prices is similar. The overall take-away is that Delaware private plans currently pay over double what Medicare pays in Delaware for selected hospital services. The ratio of private-to-Medicare prices in Delaware is also higher than the ratios of private-to-Medicare prices in Delaware's neighboring states of Pennsylvania and Maryland.

One could argue that the Medicare program pays too little, however national data suggest that most efficient hospitals would not be unprofitable if hospitals were paid Medicare rates.[2] Hospitals generally spend available resources; thus, when private insurers pay higher prices, hospital costs usually increase.[3] Using the 2017 Medicare Cost Report,[4] we examined the overall margins and operating margins of short-term general hospitals in Delaware. Overall margin is defined as the total net income from all resources divided by net patient revenue. Operating margin is defined as the patient net income divided by net patient revenue. We found that that among the six Delaware hospitals, overall margins ranged between 3.1 percent and 15.2 percent, with a median of 11.4 percent; operating margins ranged between -5.1 percent and 8.7 percent with a median of 3.1 percent (Table 2). We also examined all 4,517 short-term general hospitals in the nation. Their median overall margin and operating margin were 3.6 percent and -2.6 percent, respectively. In comparison, Delaware hospitals' median overall margin and operating margin were both substantially higher than the national median.

Table 2. Hospital Margins in Delaware, 2017[4]

Hospital name	**City**	**Number of beds**	**Overall margin**	**Operating margin**
Beebe Medical Center	Lewes	193	9.8%	8.7%
ChristianaCare	Wilmington	1061	14.5%	-5.1%
Kent General Hospital	Dover	281	15.2%	5.0%
Milford Memorial Hospital	Milford	124	13.0%	3.6%
Nanticoke Memorial Hospital	Seaford	94	8.3%	2.7%
St. Francis Hospital Wilmington	Wilmington	180	3.1%	-0.3%
National average (4,517 hospitals)	-		3.6% (median)	-2.6% (median)

As of 2017, 53 percent of Delawareans received health insurance through their employer. Delaware private plans currently pay approximately twice what Medicare pays for selected hospital services and hospitals in the state are, on average, doing better than hospitals nationally. Higher prices for hospital services that are borne by employers are passed on to employers and employees in the form of higher premiums and deductibles. In turn, higher cost-sharing may lead to forgone employer profit and employee take-home pay. Opportunities exist for the state to address this issue and balance access, cost, and quality of the Delaware hospital market.

To immediately reduce the burden of high prices on Delaware employees, policymakers may consider enacting protections against surprise billing. "Surprise billing" occurs when an individual seeks care at a facility that is in their insurer's network, but receives a bill from an out-of-network physician who is practicing at that facility. Their insurer may cover part of the bill, but then the patient may receive a bill for the difference between the physician's charge and

the insurer's payment. There is broad agreement that consumers should be protected from these potentially substantial bills, prompting federal and state policymakers to take action. Delaware has partial protections against surprise bills in place, however these protections could be made more comprehensive.[5]

"Surprise" bills make up a small amount of health care spending. Delaware could take further action by implementing broader, but still targeted, price regulation. For example, the state could reduce rates paid for services used by state employees by 20 percent every year so that the gap between their prices and Medicare rates is closed over five years. Reducing rates for state employees would improve access to care for employees and reduce state spending on health care. Those savings could then be directed into higher wages or other priority areas for the state. Several states, including California and Montana, have enacted legislation tying rates paid for state employees' health care directly to Medicare rates. For example, Montana pays 234 percent of Medicare rates for services provided to state employees. The state reports that this policy has been a success, saving the state $15.6 million this year without adverse effects on hospitals.[6] California has taken a narrower approach, setting rates for state employees for a select set of procedures (and expanding this set over time).

The state may also consider removing regulatory barriers such as "Certificate of Need" laws, which require health care facilities to appeal to a state board before expanding, building, or acquiring a new service. Evidence has shown that these laws have not had the intended effects of controlling costs or improving quality.[7] Instead, they have allowed existing hospitals to keep competitors out of the state, thereby reducing competition – and leading to higher prices. To date, 15 states have repealed their Certificate of Need laws, however Delaware's remain in place.

Other states have undertaken a range of actions with the goal of lowering private sector health care prices, including targeted price regulation, promoting competition in provider markets, and investing in alternative payment models (e.g., global budgets for rural hospitals).[8] Our data shows that Delawareans who receive insurance through their employer currently pay more than twice as much for hospital services than Medicare pays. At the same time, Delaware hospitals generally have higher profits than the national average. Lowering health care prices would help Delaware residents access services and reduce the financial burden on the state and employees without threatening the financial viability of the state's hospitals.

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