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High-Price Hospitals Bigger but Not Necessarily Better

Health Affairs Study Finds High-Price Hospitals Tend to Be Larger, Belong to Systems with Large Market Share and Provide Specialized Services, but Quality Indicators Mixed

News Release
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WASHINGTON , DC—While higher-price hospitals tend to be bigger, have larger market shares and offer expensive specialized services, they don't necessarily provide better quality of care than lower-price hospitals, according to a study from the nonpartisan, nonprofit National Institute for Health Care Reform (NIHCR) published today as a Web First by *Health Affairs*.

Conducted for NIHCR by researchers at the former Center for Studying Health System Change (HSC), the study used 2011 claims data for active and retired nonelderly autoworkers and their dependents to examine prices paid by private health plans for 24,187 inpatient stays in 110 hospitals across 10 U.S. metropolitan areas—Buffalo, N.Y.; Cleveland; Detroit; Flint, Mich.; Indianapolis; Kansas City; St. Louis; Toledo, Ohio; Warren, Mich.; and Youngstown, Ohio.

Previous HSC research found that hospital prices paid by private health plans vary widely within communities, with the highest-price hospital in a market typically paid 60 percent more for the same inpatient services than the lowest-price hospital. The new *Health Affairs* study linked hospital-specific negotiated private health plan prices with detailed information on hospital characteristics to better understand differences between high- and low-price hospitals.

Along with being larger and more likely to provide specialized services, such as Level I trauma care and heart transplants, high-price hospitals in the study tended to be major teaching hospitals; receive significant revenue from non-patient sources; treat more low-income patients, and have negative operating margins but positive total profit margins.

Quality indicators for high-price hospitals were mixed. High-price hospitals fared much better than low-price hospitals in *U.S. News & World Report* rankings, which are based largely on reputation, but they generally scored worse on objective measures of

quality, such as postsurgical mortality rates.

“Our findings support both prevailing views about why prices vary so much among hospitals—many high-price hospitals have unique characteristics that increase their costs, and they often have market power that allows them to negotiate high prices



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costs, and they often have market power that allows them to negotiate high prices with private health plans and operate under little pressure to contain costs,” said Chapin White, Ph.D., a former HSC researcher now at RAND, and coauthor of the study with James D. Reschovsky, Ph.D., a former HSC researcher now at Mathematica Policy Research; and Amelia M. Bond, a former HSC analyst.

Other key findings, detailed in the *Health Affairs*’ article, titled “Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs,” include:

- High-price hospitals averaged 474 beds—more than double the average number of beds in low-price hospitals—and had market shares about three times as large as low-price hospitals.
- Each high-price hospital in the study on average accounted for 11 percent of patient days in its market, but affiliations with larger hospital systems appeared to increase negotiating clout. High-price hospitals belonged to systems that on average accounted for 28 percent of patient days in the market—more than double the share associated with low-price hospitals.
- Nearly half of high-price hospitals were major teaching hospitals, compared to 17 percent of low-price hospitals. High-price hospitals also were more likely to offer specialized services, including Level I trauma care, neonatal intensive care and heart transplants.
- Compared to low-price hospitals, high-price hospitals treated sicker and poorer patients, had more patients transferred from other hospitals, and provided more graduate medical education.
- High-price hospitals on average had negative operating margins (-2.8%)—just revenue from patient care—but positive total margins (4.5%)—revenue from all sources. High-price hospitals rely more on revenue from sources other than patient care, especially Medicaid disproportionate share hospital, or DSH, funding designed to offset the costs of caring for many low-income and uninsured patients.
- High-price hospitals performed much better than low-price hospitals on reputation-based quality measures. No low-price hospital was nationally ranked by *U.S. News & World Report* for cancer, cardiology, gynecology or orthopedics, while nearly a quarter of high-price hospitals were nationally ranked in one or more of those specialties.
- High-price hospitals’ performance on outcome-based quality measures was mixed. They performed worse than low-price hospitals on measures of excess readmissions and patient-safety indicators, including post-surgical deaths and complications. The only quality measure the high-price hospitals performed better on was 30-day mortality rates for heart failure patients.

The authors conclude that insurers may face resistance if they try to steer patients away from high-price hospitals because these facilities have good reputations and offer specialized services that may be unique in their markets.

“Given the intense and growing pressure to rein in the growth in private health insurance premiums, the continuation of current trends appears to be unsustainable. It remains to be seen whether or not health plans will somehow regain the upper hand. If they do not, more radical approaches—such as state-based rate setting or restrictions on contracting arrangements between hospitals and health plans—may gain traction,” the article states.

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