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Methodology: How the WSJ Analyzed Hospital Pricing Data

As of January, U.S. hospitals are required to disclose the rates for all services that they have negotiated with insurers and the price they charge uninsured people who pay out of their own pocket



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Federal regulations that went into effect in January require U.S. hospitals to disclose the rates for all services that they have negotiated with insurers. For each service—everything from a simple X-ray to an emergency-room visit to a complicated surgery—the disclosures are required to include:

- The “chargemaster,” or list, price that a hospital has set for the service. While this price is rarely charged to anyone, many hospitals use it as a starting point for negotiations over what they will charge.
- The price that a cash-paying patient, such as someone who is uninsured, would be charged for the service.
- Each price that the hospital has negotiated with a private insurer’s Medicare Advantage or commercial (typically employer) health plan.

The Journal reviewed hospital pricing disclosures collected by Turquoise Health Co., a startup that has been gathering the data from hospital websites since the regulations went into effect.

The Journal's analysis was limited to acute-care (short-term) hospitals; rural, primary-care hospitals; and children's hospitals. Turquoise's database of providers includes 4,884 of those types of hospitals, but as of June 18, the company has found that 1,671, or 34%, of those hospitals hadn't posted any usable pricing data, while an additional 570, or 12%, had posted data that fell well short of the requirements.

For its analysis of the prices hospitals charge to uninsured, self-paying customers, the Journal examined hospitals' pricing disclosures for 17 services identified by federal data and experts as those likely to be used often by uninsured patients in emergency situations. Those services, and the CPT (Current Procedural Terminology) or DRG (Diagnostic Related Group) codes used in the industry to identify them, are:

- Emergency-room visits (five different levels of complexity). CPT codes 99281-99285
- Appendectomies (six different levels of complexity). DRG codes 338-343
- Basic metabolic panel. CPT 80048
- Comprehensive metabolic panel. CPT 80053
- Chest X-ray with two views. CPT 71046
- CT scan of the head or brain without contrast. CPT 70450
- Electrocardiogram. CPT 93005
- Cardiovascular procedure with drug-eluting stent. DRG 247

In the data Turquoise had collected as of June 18, there were 1,550 hospitals that had reported both negotiated rates and the cash, or self-pay, price for at least one of the 17 services in the Journal's analysis.

To analyze how cash prices compared with the rates that hospitals charged to commercial insurers and Medicare Advantage plans, the Journal calculated the percentile of where each negotiated rate or cash price fell within the range of prices for each service at each hospital, using the `ecdf` function in the statistical program R.

This table shows an example of the negotiated rates and the cash, or self-pay, price one hospital reported for a complex emergency-room visit (CPT 99285), with the percentile where each rate fell within the range of prices calculated by the Journal.

INSURER	PLAN NAME	RATE	PERCENTILE
HUMANA	NWR HUMANA HMO	\$675	7%
UNITED HEALTHCARE	NWR UHC CORE	\$864	13%
AETNA	NWR AETNA NM EMPLOYEES	\$913	20%
HUMANA	NWR HUMANA PPO	\$920	27%
UNITED HEALTHCARE	NWR UHC HMO/PPO	\$936	33%
CIGNA	NWR CIGNA LOCAL PLUS	\$1,344	40%
BLUE CROSS BLUE SHIELD	BCBS BLUE CHOICE	\$1,367	47%
BLUE CROSS BLUE SHIELD	BCBS PPO	\$1,608	53%
AETNA	NWR AETNA IL PREFERRED NEW BUSINESS	\$1,610	60%
CIGNA	NWR CIGNA C	\$1,706	67%
BLUE CROSS BLUE SHIELD	BCBS HMO	\$1,822	73%
HEALTH ALLIANCE	HEALTH ALLIANCE	\$2,149	80%
AETNA	NWR AETNA	\$2,153	87%
CIGNA	NWR CIGNA	\$2,217	93%
CASH PRICE	CASH PRICE	\$2,817	100%

In total, the Journal’s analysis included 15,581 examples of the rates hospitals charged for the services.

The Journal found that half of the cash rates in those examples were at or above the 60th percentile of all rates disclosed by the hospitals. A quarter of the cash rates were at the 93rd percentile or higher. And 23% of the cash rates were at the 100th percentile—higher than any of the negotiated rates.

Hospitals routinely negotiate or apply standard discounts for uninsured patients.

In addition to the pricing data, the Journal compiled and analyzed Internal Revenue Service data for 3,144 nonprofit hospitals. On IRS Form 990 Schedule H, the nonprofit hospitals

disclose the income limits patients must fall below in order to qualify for free or discounted care. For-profit hospitals aren't required to disclose this information to the IRS.

The policies are typically pegged to the official U.S. poverty level, which for a one-person household currently is an annual income of \$12,880.

The Journal found that 392 of the nonprofit hospitals cut off free care as soon as a patient's income exceeds the poverty level.

For the least generous quarter of the hospitals, the income cutoff for free care is 1.6 times the poverty level or less. On the other end of the scale, 461 of the hospitals have income cutoffs for free care that range from three to six times the poverty level. Some hospitals consider household assets in setting a cutoff for free care.

Hospitals may also discount medical bills for households that earn too much for free care. The size of the discount is typically also determined by income, with a cutoff beyond which patients must pay the full bill.

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