RESEARCH LETTER

Cash and Commercial Negotiated Prices of Physician-Administered Drugs in US Hospitals

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ABSTRACT

Using nationally representative data, we found that for common physician-administered drugs, hospitals' cash prices are frequently lower than their median—and sometimes even their lowest—commercial negotiated prices. This finding is important for uninsured patients and patients enrolled in high-deductible health plans, the number of whom is expected to grow due to recent and prospective policy changes in Medicaid and the individual markets. Assembling patient-friendly databases and applications that incorporate cash prices, the lowest negotiated prices, and Medicare rates could facilitate patients' comparison shopping and enhance patient access.

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The 2021 federal hospital price transparency rule requires hospitals to publicly disclose both their cash and commercial negotiated prices for hospital services. Prior research based on the disclosed data has found that cash prices are often lower than negotiated prices.[1-3] However, little is known about this relationship for physician-administered drugs. Understanding this relationship has important implications for uninsured patients and patients enrolled in high-deductible health plans, the number of whom is expected to grow due to recent and prospective policy changes in Medicaid and the individual markets.[4,5] In this study, we used a large national data set to compare cash and negotiated prices for common physician-administered drugs within the same hospital.

METHODS

We used the CMS Part B Spending Dashboard to identify the 20 highest-spending physician-administered drugs in traditional Medicare.[6] We then used May 2024 publicly disclosed pricing information compiled by Turquoise Health, whose data has been used in prior academic research.[1-3] Hospitals that reported prices for fewer than 3 drugs or could not be matched to the American Hospital Association database by Medicare identifier were excluded.

Because each commercial plan negotiates its own price, we calculated the within-hospital lowest, median, and highest negotiated prices for each drug and compared them to the hospital's cash price to determine the percentage of hospitals where the cash price was lower than the lowest, median, and highest negotiated prices. Within-hospital comparisons avoided price measurement noise stemming from inconsistently reported drug units and dosing across hospitals, which posed challenges for between-hospital comparisons. Finally, we compared hospital characteristics between those with cash prices lower than median commercial prices for the 3 most common drugs (ie, denosumab, infliximab, and octreotide) and other hospitals with available data.

RESULTS

The 20 highest-spending physician-administered drugs in traditional Medicare are listed in **TABLE 1**. A total of 2137 unique hospitals disclosed both cash and commercial negotiated prices for at least 3 of these drugs (**eAPPENDIX** [available at **ajmc.com**]). The number of hospitals reporting both cash and negotiated

TAKEAWAY POINTS

- Hospitals' cash prices are frequently lower than their commercial negotiated prices for common physician-administered drugs.
- Patient-friendly databases and applications could promote price competition, improve affordability, and enhance patient access.

prices for a given drug ranged from 151 for pemetrexed to 1966 for denosumab (Table 1). The median number of commercial plans per hospital negotiating for a given drug ranged from 9 to 21.

The share of hospitals where the cash price was lower than the lowest commercial negotiated price ranged from 7% for ranibizumab to 20% for pembrolizumab. Compared with the median negotiated price, the cash price was lower in 29% of hospitals for pemetrexed and 50% for rituximab plus hyaluronidase. Relative to the highest negotiated price, the cash price was lower in 58% of hospitals for pemetrexed and 81% for aflibercept.

Hospitals with cash prices lower than their median negotiated prices for the 3 most common drugs were more likely to be nonprofit, small, and located in rural areas (**TABLE 2**).

TABLE 1. Comparison of Hospital Cash Price and Commercial Negotiated Price for Common Infusion Drugs, 2024

HCPCS code	Drug description	No. of hospitals[a]	Median (IQR) No. of commercial insurance plans[b]	% hospitals: cash price < lowest commercial price	% hospitals: cash price < median commercial price	% hospitals: cash price < highest commercial price
J0129	Abatacept, 10 mg	1478	16 (9-28)	14.5	46.8	63.7
J0178	Aflibercept, 1 mg	343	18 (8-29)	10.5	43.7	81.1
J0717	Certolizumab pegol, 1 mg	1004	16 (10-29)	12.6	43.9	60.2
J0897	Denosumab, 1 mg	1966	16 (9-27)	9.8	44.3	69.9
J1300	Eculizumab, 10 mg	1059	18 (11-32)	12.4	43.3	65.3
J1745	Infliximab, excludes biosimilar, 10 mg	1888	16 (9-27)	11.8	43.2	68.2
J2350	Ocrelizumab, 1 mg	1177	16 (9-28)	14.4	48.5	61.9
J2353	Octreotide (depot, IM injection), 1 mg	1459	17 (10-28)	12.3	47.2	69.0
J2354	Octreotide, (nondepot, SC/IV injection), 25 mcg	1786	14 (8-24)	9.7	47.4	80.6
J2357	Omalizumab, 5 mg	1493	17 (9-29)	10.5	45.8	67.3
J2506	Pegfilgrastim, excludes biosimilar, 0.5 mg	1316	16 (9-28)	10.6	45.1	67.3
J2778	Ranibizumab, 0.1 mg	338	21 (9-39)	7.4	42.0	66.6
J9022	Atezolizumab, 10 mg	1261	17 (10-28)	13.1	44.7	65.0
J9035	Bevacizumab, 10 mg	1428	17 (11-29)	8.5	40.8	65.6
J9144	Daratumumab, 10 mg and hyaluronidase-fihj	980	17 (9-30)	16.3	47.1	62.6
J9145	Daratumumab, 10 mg	1157	18 (10-29)	10.3	41.3	66.9
J9173	Durvalumab, 10 mg	1160	17 (10-29)	9.9	44.7	61.8
J9271	Pembrolizumab, 1 mg	1464	16 (9-28)	20.4	48.2	67.6
J9299	Nivolumab, 1 mg	1412	16 (10-28)	8.4	44.4	67.9
J9304	Pemetrexed (Pemfexy), 10 mg	151	9 (2-14)	15.9	28.5	58.3
J9305	Pemetrexed, 10 mg	1462	17 (10-28)	13.1	42.1	68.7
J9311	Rituximab, 10 mg and hyaluronidase	668	17 (10-31)	10.6	49.6	65.3
J9312	Rituximab, 10 mg	1634	16 (9-27)	8.5	44.4	69.1
J9355	Trastuzumab, 10 mg	1387	17 (10-29)	10.1	42.4	61.1
Mean		1228	16.5	11.7	44.1	66.7

HCPCS, Healthcare Common Procedure Coding System; IM, intramuscular; IV, intravenous; SC, subcutaneous.

[a]Hospitals include those disclosing both the cash price and commercial negotiated prices for the drug.

[b]*Commercial insurance plans* refers to insurance plans with prices for the drug.

DISCUSSION

Using nationally representative data, we found that for common physician-administered drugs, hospitals' cash prices are frequently lower than their median—and sometimes even their lowest—commercial negotiated prices. Some hospitals may set competitive cash prices to attract price-sensitive uninsured and underinsured patients for direct transactions, thereby avoiding the administrative complexities and payment delays associated with insurance.

Our analysis extends prior literature examining the relationship between hospital cash prices and commercial negotiated prices,[1-3] as well as commercial pricing for physician-administered drugs.[7] Due to its descriptive nature, this study is unable to identify factors influencing this relationship (eg, the 340B Drug Pricing Program), which presents a promising area for future research. The results, based on hospitals that disclosed pricing information, may not be generalizable to all hospitals or to specific subsets characterized by particular ownership, teaching status, specialty, or other factors.

Hospitals' self-disclosed pricing information, due to the size, technicality, and storage format, is typically inaccessible to average patients. Private companies and government agencies at the federal and state levels could consider assembling patient-friendly databases and applications that incorporate cash prices, the lowest negotiated prices, and Medicare rates to facilitate patients' comparison shopping for drugs and hospital services. These efforts could promote price competition, improve affordability, and enhance patient access. ■

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TABLE 2. Comparison of Characteristics: Hospitals With Cash Prices Less Than Median Commercial Prices for All 3 Common Drugs vs Other Hospitals, 2024[a]

Hospital characteristics	Cash price < median commercial price for all 3 drugs[b] (n = 477)	Other hospitals with available data[c] (n = 1078)
Ownership		
Nonprofit***	79.6%	68.7%
For profit	5.8%	16.4%
Government	14.7%	14.9%
Rural location***	27.1%	17.3%
Teaching hospital	41.7%	45.9%
System affiliated	74.4%	76.8%
Size		
≤ 99 beds***	48.0%	34.7%
100-199 beds	15.8%	23.0%
200-399 beds	18.7%	25.0%
400-599 beds	4.9%	9.6%
≥ 600 beds	12.7%	7.8%
Census region		
New England***	4.0%	5.8%
Mid-Atlantic	7.6%	8.9%
East North Central	23.1%	15.4%
West North Central	11.6%	13.3%
South Atlantic	19.8%	16.6%
East South Central	8.0%	7.8%
West South Central	6.2%	10.2%
Mountain	10.4%	9.5%
Pacific	9.3%	12.5%

[a]Rows with *** have a *P* value from a *t* test of the mean < .01. No other *t* test results had a *P* value between .01 and .1.

[b]The 3 drugs—denosumab, infliximab, and octreotide—have the highest number of hospitals reporting both cash prices and commercial prices. A total of 1555 hospitals reported both cash prices and commercial prices for all 3 drugs. Hospitals in this column reported cash prices that were lower than their median commercial prices for all 3 drugs.

[c]Hospitals that did not report cash prices that were lower than their median commercial prices for all 3 drugs are included in this column.

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eAppendix. Flow chart of inclusion and exclusion criteria to arrive at the final sample of hospitals