



Hospital Prices in Wisconsin and Illinois: A Cross-State Comparison*

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August 14, 2026

*The views expressed herein are those of the authors and not necessarily those of the Center for Research on the Wisconsin Economy, the Department of Economics, or the University of Wisconsin – Madison.

Executive Summary

This report compares hospital prices between Wisconsin and Illinois using commercial negotiated-rate data drawn from hospital and payer price-transparency filings. The analysis covers roughly 70 hospitals in Illinois and 60 in Wisconsin, spanning dozens of health systems and a set of high-spend inpatient services, for the Blue plan and UnitedHealthcare in each state. Across this sample, Wisconsin hospital prices are consistently and substantially higher than prices for the same services in Illinois.

Three central findings emerge:

- **Wisconsin hospital prices are roughly 26 percent higher overall.** Controlling for the specific service and payer, Wisconsin negotiated rates exceed Illinois rates by approximately 26 percent. The estimate focuses on inpatient (MS-DRG) services, where the premium is +25.6 percent and proves highly stable. The relationship holds across regression specifications, the inclusion of hospital facility-type and teaching-status controls, across the two payers examined, and when reproduced in an independent hospital-reported data source.
- **The premium persists within the same health system.** Advocate Health operates hospitals on both sides of the Illinois–Wisconsin border. Within this single system, holding corporate governance, brand, and clinical scope constant, Wisconsin hospitals are paid about 23 percent more for inpatient services than the system’s Illinois hospitals.
- **The premium is broad and consistent.** The two carriers with robust negotiated dollar-value contracts in both states, the Blue plan and UnitedHealthcare, independently show nearly identical inpatient premiums of +25.8 percent and +25.4 percent, indicating that the gap is a feature of the Wisconsin provider market rather than any single insurer’s contracting strategy. Every one of the 24 inpatient procedures examined is more expensive in Wisconsin, spanning obstetric, surgical, cardiovascular, and medical service lines.

Taken together, these findings point to market structure, rather than service mix, hospital type, or insurer behavior, as the leading candidate explanation for Wisconsin’s elevated hospital prices. Subsequent phases will investigate hospital consolidation, service-line restructuring, and the emergence of provider-sponsored health plans as potential structural drivers of these patterns.

1. Introduction

Healthcare spending in Wisconsin has risen steadily over the past two decades, and multiple national benchmarking studies, including successive [RAND Hospital Price Transparency reports](#), have identified Wisconsin as one of the highest-priced hospital markets in the country. Despite broad recognition of this pattern, the underlying sources of elevated spending remain poorly understood. Public discourse often centers on insurer behavior or benefit design, but less attention has been paid to the structural dynamics of local provider markets and the extent to which hospital consolidation and vertically integrated health systems may be shaping price levels.

This project develops a rigorous, evidence-based assessment of hospital pricing in Wisconsin to support informed policy dialogue. As a first step, we measure how hospital prices in Wisconsin compare with those in Illinois, a neighboring state with broadly similar demographics. By examining prices for a common set of payers and, in some cases, hospital systems operating across both states, this phase provides an apples-to-apples price comparison. The analysis draws on two complementary sources of price transparency: payer-reported and hospital-reported machine-readable files. We anchor our conclusions on the payer-reported negotiated rates and use the hospital-reported file as an independent corroborating source.

The specific objectives of our work are to:

- Quantify the overall price gap between Wisconsin and Illinois for a standardized set of services.
- Examine pricing differences within the same hospital system (Advocate Health) across state lines, to determine whether price variation reflects underlying cost differences or market-specific pricing power.
- Evaluate how price differentials vary across insurers.
- Establish a clear empirical baseline to guide subsequent inquiry into consolidation patterns, contracting behavior, and regulatory frameworks.

By documenting the magnitude and consistency of Wisconsin's hospital price differences, we set the stage for future work to explore the underlying factors that explain them. Wisconsin's elevated price levels have significant implications for insurance premiums, employer costs, and state budgets, which makes understanding their structural origins a matter of direct policy relevance.

2. Data Overview

This analysis draws on two complementary hospital price transparency datasets, both obtained from Turquoise Health, a healthcare data analytics vendor, covering commercial-payer hospital prices in Wisconsin and Illinois. The two files reflect the two sides of the federal hospital-price-transparency framework:

- **Payer-reported negotiated rates** are derived from machine-readable files (MRFs) published by health insurers under the Transparency in Coverage rule. Rates reflect negotiated values reported by each payer for a given carrier and state. Before analytic screens, the file covers 99 Illinois and 87 Wisconsin hospitals across three national commercial carriers (UnitedHealthcare, Aetna, Cigna) and the dominant Blue plan in each state (BCBS-IL and Anthem in Wisconsin).
- **Hospital-reported standard charges** are derived from hospital MRFs published under the CMS hospital price transparency rule. Hospital-posted rates may be a negotiated dollar amount, an estimated allowed amount derived from a posted percentage of billed charges, or a negotiated percentage. Before analytic screens, the coverage here is broader: 119 hospitals in Illinois and 110 in Wisconsin.

Together, the two files cover roughly 250 unique hospitals across dozens of systems and healthcare markets in the two states: 186 in the payer-reported file and 229 in the hospital-reported file, with 163 hospitals appearing in both. (These counts describe raw file coverage; the analytic sample, after the inclusion screens and the carrier exclusions described below, is smaller, as reported in Table 2.) Services are reported for approximately 53–56 billing codes (MS-DRGs for inpatient services, HCPCS/CPT for outpatient services), selected to represent a high-spend subset of services for which transparency-data coverage is reliable. The code subset represents roughly fifteen percent of total commercial hospital spend in each state. As explained in Section 4, the cross-state comparison focuses on inpatient (MS-DRG) services; the smaller number of outpatient codes available to us do not support reliable cross-state comparisons and are not used.

To ensure that commonly used services are weighted appropriately within the analyzed subset, the analysis applies state-specific spend-share weights for each code. These weights reflect each code's share of commercial hospital spending across the analyzed high-spend code subset and are used as probability weights in the weighted analyses reported in Section 3. The full set of inpatient weights used in the analysis is reported in Appendix Table A1.

We use the payer-reported file as our primary data source and the hospital-reported file as a corroborating source. Two structural considerations motivate this choice. First, the payer

file most commonly reports a single negotiated-rate field at the carrier-and-state level, whereas the hospital file reports rates under several contract methodologies (negotiated dollar amounts, percent-of-charge estimates, and per-diem or percentage arrangements) and across many more distinct network labels; these reporting differences are handled explicitly through the inclusion screens described in Section 4. Second, the inpatient MS-DRG rates in the two files agree closely where they overlap: among hospital $\times$ DRG cells reported in both files, the median ratio of hospital-reported to payer-reported rates is exactly 1.00, with two-thirds of cells agreeing within ± 10 percent. This establishes that the two sources measure the same underlying contracted rate for inpatient services.

Carrier coverage and the Blue plan structure

The dataset contains rates for four payer categories: three national commercial insurers—UnitedHealthcare, Aetna, and Cigna—and the dominant Blue plan operating in each state. The Wisconsin Blue plan is Anthem Blue Cross; the Illinois Blue plan is Blue Cross Blue Shield of Illinois, operated by Health Care Service Corporation (HCSC). Although these are two distinct legal entities, each functions as the dominant Blue-branded commercial payer in its state, and the cross-state Blue comparison therefore reflects the actual market structure faced by Wisconsin and Illinois patients with Blue coverage.

The primary estimate rests on the two carriers that file a substantial book of fixed negotiated dollar rates in both states: the Blue plan and UnitedHealthcare. Aetna and Cigna are reported separately rather than in the primary estimate, because their Wisconsin payer filings consist overwhelmingly of per-diem and percentage-based rates rather than fixed negotiated dollars, leaving too few comparable observations once the inclusion screens are applied. The reasons are documented in Section 4, and an estimate for each carrier computed entirely within the hospital-reported file is presented as a robustness check.

Cross-state system overlap

Advocate Health (formerly Advocate Aurora Health) operates hospitals on both sides of the Illinois–Wisconsin border under the same parent system: nine acute-care hospitals in Illinois (operating as Advocate Health Care) and thirteen in Wisconsin (operating as Aurora Health Care). This creates a natural within-system comparison that holds corporate governance, brand identity, and organizational scope approximately constant, allowing observed price differences across the border to be attributed to market-specific competitive conditions rather than to internal cost or management structure. Within-system results are reported in Section 3.c.

Why Illinois is an appropriate comparison state

Illinois is an appropriate benchmark for Wisconsin. The two states are demographically and economically similar on the dimensions most relevant to commercial hospital pricing,

as the American Community Survey (ACS) and the decennial Census show (Table 1).

The two states track closely on median age (40.2 versus 39.0), median household income (within roughly seven percent), the poverty rate (10.6 versus 11.8 percent), private and employer-based coverage (53.6 versus 52.3 percent), and the uninsured rate (5.2 versus 6.9 percent). These are the population and benefit-design features that most directly shape commercial hospital demand. The two states also share a regulatory framework for rate review and benefit mandates and a comparable prevalence of self-insured large employers. Where they diverge is in geography and provider market structure. Illinois is substantially more urban (87 versus 67 percent), and Wisconsin's hospital markets are dominated by a handful of large, vertically integrated systems with extensive control over physician supply, service lines, and affiliated health plans, whereas Illinois, despite also having large systems, maintains a more competitive landscape with greater payer choice, larger independent physician groups, and more fragmented regional markets. The shared demographic and coverage features support a clean baseline comparison, while the divergence in market structure is the candidate explanation that our analysis is designed to test empirically.

Table 1: Demographic and coverage comparison, Wisconsin versus Illinois.

Characteristic	Wisconsin	Illinois
Population	5.9 million	12.7 million
Median age	40.2	39.0
Median household income	\$77,485	\$83,390
Poverty rate	10.6%	11.8%
Uninsured (under age 65)	5.2%	6.9%
Private / employer-based coverage	53.6%	52.3%
Urban population share	67%	87%

Population, age, income, poverty, and coverage figures are American Community Survey 1-year estimates; the urban population share is from the 2020 decennial Census.

3. Results

3.a. Sample and descriptive statistics

Before the controlled comparison, we describe the analytic sample and the unadjusted price differences it contains. Table 2 summarizes the inpatient payer-reported analytic sample, restricted to the two primary carriers (the Blue plan and UnitedHealthcare) after the inclusion screens of Section 4.

The two states are broadly comparable in scope. They have similar hospital counts (67 versus 58), an identical number of distinct health systems (20 each), and the same two commercial payer groups. The inpatient comparison rests entirely on acute-care general

Table 2: Inpatient analytic sample by state (payer-reported file, Blue and UnitedHealthcare).

	Illinois	Wisconsin
Hospitals	67	58
— all acute-care general hospitals	67 (100%)	58 (100%)
— Teaching	40 (60%)	26 (45%)
Distinct health systems	20	20
Commercial payer groups	2 (Blue, UHC)	2 (Blue, UHC)
Inpatient MS-DRGs	26	24
Observations (hospital × payer × code)	1,439	1,447

hospitals in both states; critical-access hospitals, which are more common in Wisconsin, and specialty children's hospitals report essentially no inpatient MS-DRGs that survive the inclusion screens and so do not enter the comparison (see Section 4). The states do differ in teaching intensity: 60 percent of the Illinois inpatient hospitals are teaching hospitals, versus 45 percent in Wisconsin, reflecting Wisconsin's more rural hospital landscape.

Unadjusted price differences. Pooling across the analyzed codes, the raw median inpatient negotiated rate is \$31,054 in Wisconsin versus \$23,208 in Illinois, a 34 percent gap. This unadjusted difference is confounded by between-state differences in service mix and payer mix, and the distribution of negotiated rates is right-skewed (the inpatient mean exceeds its median by a factor of roughly 1.7). Both features motivate the log-price, fixed-effects specification used in the controlled analysis that follows, which compares prices for the same service and payer.

Hospital composition does not drive the gap. Because Wisconsin's sample is weighted somewhat more toward non-teaching hospitals, we verified that the premium is not an artifact of hospital type. Adding facility-type and teaching-status fixed effects to the inpatient specification leaves the estimate essentially unchanged, going from +25.5 percent to +26.6 percent, confirming that the Wisconsin premium reflects within-hospital-type pricing rather than a different mix of hospitals. The within-system Advocate Health comparison in Section 3.c, which holds the hospital organization constant, reinforces this conclusion.

3.b. Overall Wisconsin–Illinois price comparison

3.b.i. Weighted price index

Examining each billing code's weighted mean price in the two states reveals a uniform Wisconsin premium for inpatient services. Among the 24 inpatient MS-DRGs reported in both states, all 24 services lie above the 45-degree line in Figure 1, implying that every inpatient service in the analyzed set is more expensive in Wisconsin. The weighted geometric-mean premium is +26.8 percent per code.

Figure 1 plots the weighted mean price per billing code in Wisconsin (vertical axis) against the weighted mean price for the same code in Illinois (horizontal axis), on a log scale. The dashed line marks equality between the two states; points above the line are codes for which Wisconsin is more expensive.

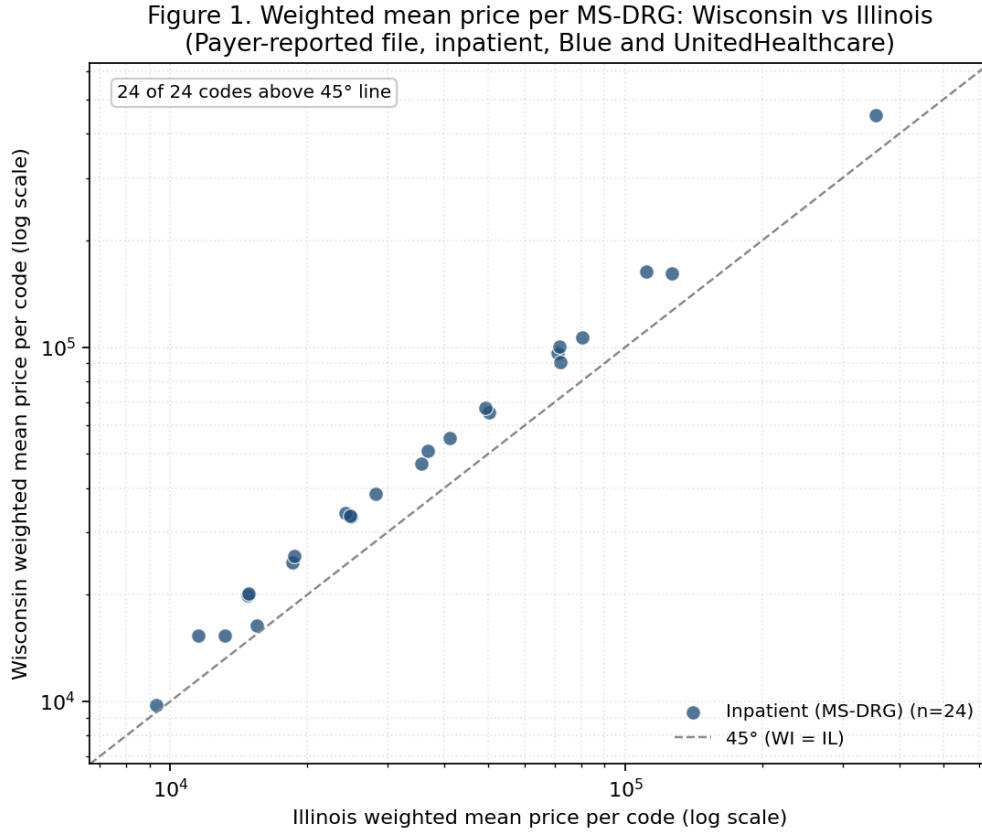


Figure 1: Weighted mean price per MS-DRG: Wisconsin versus Illinois. Each point is one inpatient billing code; axes are weighted mean negotiated rates in each state, log scale. The dashed line marks equality. All 24 DRGs lie above the line.

3.b.ii. Regression-based estimate

We estimate the Wisconsin premium from a weighted regression of log negotiated price on a Wisconsin indicator, comparing rates within the same service and payer, using the equation:

$$\ln(\text{price})_i = \beta \cdot \text{WI}_i + \gamma_{cp} + \varepsilon_i,$$

where γ_{cp} are fixed effects for each billing-code-by-payer combination (column 2), or for each billing code alone (column 1). Observations reflect hospital $\times$ payer $\times$ billing-code cells and are weighted by each code's state-specific share of total commercial hospital spending. Standard errors are cluster-robust at the hospital level. As discussed in Sec-

tion 4, hospital fixed effects cannot be included, because each hospital is located in exactly one state and would be collinear with the Wisconsin indicator.

The primary specification (Table 3, column 2) compares rates for the same service and the same payer. It yields $\beta = 0.228$ (SE 0.034), indicating that Wisconsin inpatient negotiated rates are 25.6 percent higher than Illinois rates, and is stable across the fixed-effects specification (+25.6 to +25.8 percent). As shown in Sections 3.a and 3.d, the estimate is invariant to the choice of additive or interacted fixed effects, to the inclusion of hospital facility-type and teaching-status controls, and across the two carriers examined.

Table 3: Weighted regression of log negotiated inpatient price on Wisconsin indicator, payer-reported file (Blue and UnitedHealthcare).

	(1) Code FE	(2) Code $\times$ Payer FE [primary]
WI vs. IL	0.229*** (0.034)	0.228*** (0.034)
Implied % difference	+25.8%	+25.6%
N (hospital $\times$ payer $\times$ code)	2,744	2,744
Hospitals (clusters)	124	124

Column 1 includes billing-code fixed effects; column 2 includes billing-code-by-payer fixed effects. Both carriers (Blue and UnitedHealthcare) retained. Cluster-robust standard errors at the hospital level in parentheses. *** $p < 0.001$.

3.c. Within-system: Advocate Health across the IL–WI border

Advocate Health operates hospitals on both sides of the Illinois–Wisconsin border. The within-system inpatient comparison covers eight Illinois hospitals (operating as Advocate Health Care) and thirteen Wisconsin hospitals (operating as Aurora Health Care) under the same parent system. Within this single organization, which holds corporate governance, brand, and clinical scope approximately constant, Wisconsin prices are again markedly higher than Illinois prices.

Table 4: Weighted regression results, Advocate Health hospitals only (inpatient).

	(1) Code FE	(2) Code + Payer FE
WI vs. IL	0.208** (0.075)	0.208** (0.075)
Implied %	+23.1%	+23.1%
Code fixed effects	✓	✓
Payer fixed effects		✓
N	616	616

Eight Illinois and thirteen Wisconsin Advocate Health hospitals. Cluster-robust standard errors at the hospital level in parentheses. ** $p < 0.01$.

Table 4 reports the same regression specifications restricted to Advocate Health hospitals. The primary specification yields $\beta = 0.208$ (SE 0.075), or +23.1 percent. This sits squarely within the cross-system inpatient estimate of +25.6 percent reported in Section 3.b, and

supports the interpretation that the WI–IL price gap reflects market-specific competitive conditions rather than internal cost structure, governance, or service mix.

3.d. Per-payer breakdown

Table 5 reports weighted inpatient regressions separately by payer, with billing-code fixed effects. The two primary carriers cluster almost exactly: the Blue plan at +25.8 percent and UnitedHealthcare at +25.4 percent. That two independent carriers land within half a percentage point of each other indicates that the Wisconsin premium is not the product of any single carrier’s contracting strategy but is a feature of the provider market that commercial payers face.

Table 5: Weighted inpatient regression results by payer, payer-reported file.

Payer	Inpatient β (SE)	IP %
Blue (HCSC-IL / Anthem-WI)	0.230*** (0.041)	+25.8%
UnitedHealthcare	0.226*** (0.037)	+25.4%
Cigna	0.424*** (0.060)	+52.7% (reported; not in primary)
Aetna	—	not estimable in payer file

*Billing-code fixed effects throughout. Cluster-robust standard errors at the hospital level in parentheses. *** $p < 0.001$. Cigna and Aetna are excluded from the primary estimate because their Wisconsin payer filings are dominated by per-diem and percentage-based rates (see Section 4); the Cigna figure shown rests on a thin, high-skewed remainder of fixed-dollar rows and is not relied upon.*

Cigna and Aetna are not part of the primary estimate. After the inclusion screens, Aetna has essentially no usable Wisconsin inpatient rates in the payer file, and the Cigna estimate rests on only about a fifth of its Wisconsin rows, a thin and high-skewed remainder. Both carriers are instead assessed within the hospital-reported file, where Wisconsin and Illinois data come from the same source (Section 3.f and Section 4). The robustness of the headline does not depend on them: the premium is independently estimated at +25.8 percent and +25.4 percent on the two carriers with full negotiated-dollar books, and is reproduced in the hospital-reported file.

3.e. Breadth across procedures

Figure 2 displays the per-DRG Wisconsin premium for each of the 24 inpatient MS-DRGs reported in both states, labeled by procedure and sorted from smallest to largest. All 24 DRGs show a positive Wisconsin premium, none favoring Illinois, and the magnitude is concentrated in a broad band from roughly +5 percent to +47 percent, consistent with the regression-based pooled estimate. That every individual DRG shows a positive premium is a stronger version of the regression finding: it cannot be attributed to a small number of high-priced services pulling up an average. The pattern spans diverse clinical domains—obstetrics (Normal Delivery, C-Section), cardiovascular surgery (CABG, Cardiac valve surg.), digestive procedures (Cholecystectomy, other digestive surg.), medical

admissions (Septicemia/sepsis, Cardiology, Pulmonology), and neurosurgery—indicating a system-wide rather than service-line-specific pricing pattern.

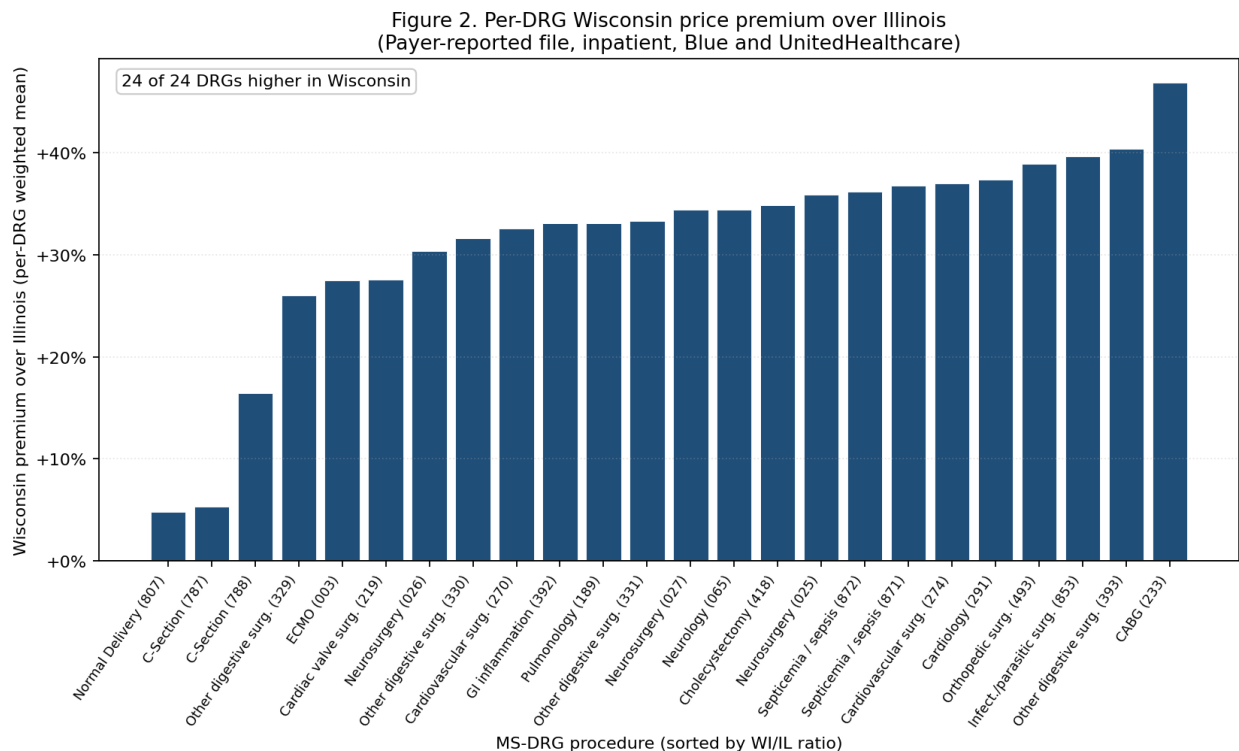


Figure 2: Per-DRG Wisconsin price premium over Illinois. Each bar is one MS-DRG, labeled by procedure (DRG number in parentheses). Bar height shows the WI-vs-IL percentage difference in weighted mean price. Sorted by magnitude. All 24 DRGs are higher in Wisconsin.

3.f. Robustness: hospital-reported data

As a check on the primary findings, which rely on the payer-reported file, we reproduce the inpatient comparison using the hospital-reported file, restricting to rows that pass the screens described in Section 4. The hospital-reported inpatient estimate is +21.0 percent across all payers and +23.0 percent excluding Aetna ($\beta = 0.207$, SE 0.045), closely aligned with the payer-file inpatient estimate of +25.6 percent. This corroboration is insensitive to how percent-of-charge rows are treated: because the screens retain rows priced as a percentage of charges (which resolve to estimable dollar amounts in the hospital file), and the aggregate result is materially unchanged whether or not they are included.

Per-payer hospital-file inpatient estimates are more dispersed, as expected from the smaller within-carrier samples and each carrier's hospital and code composition. They nonetheless confirm a positive Wisconsin premium for the two carriers excluded from the payer-file primary: Aetna +14.2 percent and Cigna +41.7 percent, each computed entirely within the hospital file, with both states' data drawn from the same source. These provide the ro-

business check referenced in Section 3.d for Aetna and Cigna and are consistent with a positive Wisconsin inpatient premium across all four carriers.

4. Limitations and Data Quality Considerations

Several features of the underlying hospital-price-transparency data warrant explicit discussion, as they shape both the design and the interpretation of this analysis.

Outpatient rates do not support a cross-state comparison

We restrict the analysis to inpatient (MS-DRG) services because the outpatient codes cannot support a reliable cross-state comparison, for three compounding reasons. First, outpatient procedures are reported using HCPCS/CPT codes that different hospitals and payers price in materially different ways—some as a per-line allowed amount, others as a packaged per-procedure rate—so the same code is not always measuring the same thing, and a direct compatibility test bears this out (inpatient MS-DRG rates agree across the payer and hospital files, with a median ratio of 1.00 and 68 percent of cells within ± 10 percent, whereas outpatient rates do not, with a median ratio of 0.88 and only 28 percent of cells within ± 10 percent). Second, the Illinois Blue plan (HCSC) does not report outpatient rates at the procedure level: across every outpatient code its rate falls within a narrow band of roughly \$115 to \$385, so that a complete blood count, an MRI, and a knee arthroplasty are all posted at similar values—an indication of a per-claim-line amount rather than a procedure-specific negotiated rate—which makes any cross-state Blue outpatient comparison invalid. Third, once non-comparable rate types and the non-procedure-specific Illinois Blue rates are removed, and once Cigna is set aside for the reasons below, the outpatient comparison reduces to a single carrier and a handful of codes, too thin to support a finding. We therefore report no outpatient estimate. The inpatient (MS-DRG) rates are unaffected by all three problems: they are procedure-specific, agree across the two files, and are reported by all carriers, which is why the analysis is anchored on them.

Some hospital-file rates are estimated, not negotiated

A substantial share of rows in the hospital-reported file are priced as a percentage of total billed charges (about seventy percent of inpatient rows for the national carriers, and a smaller share for the Blue plan). For these rows, the posted dollar value is an estimated allowed amount produced by applying a posted percentage to the hospital's chargemaster, so it carries each hospital's gross-charge level rather than a directly negotiated dollar amount. Because each hospital publishes its own chargemaster, these values are nonetheless estimable in dollars and broadly comparable, so rather than discard them we retain them and confirm (Section 3.f) that the hospital-file inpatient estimate is materially unchanged whether or not they are included. The payer-reported file, which reports a sin-

gle negotiated-rate field, is used as the primary source and the hospital-reported file as a corroborating source where the two have been shown to agree.

Inclusion screens

To keep the comparison to reliable, like-for-like prices, we apply a small number of inclusion screens. Each is defined so that an analyst working from the same transparency files and publicly available Medicare rates can reproduce it.

Two screens apply to both files. The first is a Medicare-ratio reasonableness band: for each rate we form the ratio of the negotiated price to Medicare's allowed amount for the same billing code (the applicable MS-DRG payment for an inpatient stay), and we keep only rows whose ratio falls between 1.2 and 10, dropping rates below 1.2 times or above ten times Medicare as implausible. This removes about sixteen percent of payer-file rows and about twenty-five percent of hospital-file rows. The second restricts the data to fixed negotiated dollar amounts, because a price expressed as a per diem or as a percentage of charges is not comparable across states. In the payer file, which carries no hospital chargemaster, we drop every row the file reports as per-diem or percentage-based and keep only fixed negotiated dollars. In the hospital file, where each hospital publishes its own gross charges, a percentage resolves to an estimable dollar amount and is retained, so there we drop only the (very few) per-diem rows.

Two further screens apply to the hospital file alone. A single-rate screen keeps the hospital-code-carrier combinations that resolve to one commercial rate, and drops cells that report several differing commercial-plan rates the file cannot separate back to an individual plan—for example, one hospital reporting two of a carrier's commercial plans at materially different rates for the same procedure, where there is no clear indication that the rate differential is related to benefit design (e.g., HMO vs. PPO plans); this removes about eighteen percent of rows. A gross-charge screen drops the small share of rows (about one percent) whose posted rate equals the hospital's full gross charge and therefore reflects no negotiated discount. After all screens, the hospital file retains roughly sixty percent of its rows.

Why Aetna and Cigna are not in the primary estimate

The primary estimate rests on the Blue plan and UnitedHealthcare, the two carriers that file a substantial book of fixed negotiated dollar rates in both states. Aetna and Cigna do not, and for the same underlying reason: in Wisconsin their payer machine-readable filings are dominated by per-diem and percentage-based rates rather than fixed negotiated dollars, which the second inclusion screen removes as non-comparable. After that screen, Aetna has essentially no usable Wisconsin inpatient rates in the payer file—only 0.7 percent of its Wisconsin rows are reported as directly negotiated dollar amounts, against fifty percent

of its Illinois rows—and Cigna retains only about a fifth of its Wisconsin inpatient rows (78 percent are per-diem or percentage-based). Turquoise has separately flagged Aetna as a low-quality data reporter, and Aetna's limited Wisconsin commercial presence (it covers the fewest Wisconsin hospitals of the three national carriers) compounds the problem.

Because these are payer-side reporting limitations rather than hospital-side data problems, both carriers can still be gauged within the hospital-reported file, where Wisconsin and Illinois data come from the same source. There, each shows a positive Wisconsin inpatient premium (Aetna +14.2 percent, Cigna +41.7 percent; Section 3.f). Excluding them from the primary therefore does not understate the gap, and the two carriers that anchor the primary estimate, Blue and UnitedHealthcare, agree almost exactly (+25.8 and +25.4 percent).

Facility mix: critical-access and children's hospitals

Critical-access hospitals are more common in Wisconsin than in Illinois, which raises the question of whether facility mix drives the gap. It does not. These small rural hospitals report essentially no inpatient MS-DRGs that survive the inclusion screens, so the inpatient analytic sample—the analysis's anchor—contains only acute-care general hospitals in both states (Table 2), and the premium is estimated entirely within that group. Critical-access hospitals appear only in outpatient rows, which the analysis does not use. Because Wisconsin's critical-access hospitals tend to price below the state average, their absence from the inpatient comparison, if anything, makes the reported premium conservative rather than inflated.

The same holds for specialty children's hospitals. Wisconsin and Illinois each host only a small number of them—broadly comparable, if anything slightly more in Illinois—and none contributes a single inpatient observation to the analytic sample: their inpatient rows either fail the negotiated-dollar and Medicare-ratio screens or are reported only as outpatient services. The largest Illinois children's hospital, for instance, files inpatient rates for eleven MS-DRGs, none of which survive the screens, while Children's Wisconsin reports outpatient rows only. Because children's hospitals are both few and roughly balanced across the two states, their exclusion neither generates nor conceals the Wisconsin premium.

Hospital volume weighting

The analysis weights services by their share of commercial spend but weights hospitals equally within each service, because the machine-readable files report negotiated prices without any transaction volume (admissions, discharges, or claim counts). The estimate therefore answers the question “what does the typical hospital charge for a given service,” not “what is spending per admission.” Two considerations indicate that equal hospital weighting does not inflate the premium. First, the inpatient anchor is computed entirely on acute-care general hospitals, which carry the great majority of admissions; the smallest,

lowest-volume facilities do not enter it. Second, adding facility-type and teaching-status controls, which absorb the broad differences in hospital size, leaves the estimate slightly higher rather than lower (Section 3.a). A definitive volume-weighted figure would require merging external discharge or bed counts—for example from the American Hospital Association annual survey or CMS cost reports—onto each hospital’s Medicare provider number, which we flag as a refinement for a later phase.

Identification of state effects

In a cross-state design, each hospital is located in exactly one state. As a consequence, hospital fixed effects are perfectly collinear with the state indicator and cannot be included in the main specification, since doing so would absorb the very effect being estimated. The reported specifications therefore include billing-code fixed effects and billing-code-by-payer fixed effects. Within-organization identification is provided by the Advocate Health analysis in Section 3.c, in which the same parent system operating on both sides of the border functions as a within-system, across-state comparison.

Code coverage

The analyzed inpatient code set comprises approximately 26 MS-DRGs, selected to represent the highest-spend services with reliable transparency data coverage. These codes represent a substantial share of inpatient commercial hospital spend in each state. This is a narrower code set than was available in the earlier draft of this analysis, but the narrower coverage is offset by substantially broader hospital coverage (over 120 hospitals in the new data versus thirteen in the prior draft) and by the application of state-specific spend-share weights, which ensure that commonly used services are weighted appropriately within the analyzed subset. The use of code fixed effects throughout further restricts the cross-state comparison to within-code variation, mitigating any concern that differential code mix between states could mechanically generate the observed price gap.

5. Conclusion

Our work establishes a clear and consistent empirical baseline: Wisconsin hospital prices are markedly higher than those in Illinois for the same services, on the order of 25 to 26 percent. The finding holds under multiple analytic approaches, including a per-code price index, regression models with billing-code and payer fixed effects, and a within-system comparison of a single cross-border health system. It is anchored on inpatient services, where the +25.6 percent premium is unusually robust: it is essentially unchanged across regression specifications, when hospital facility-type and teaching-status controls are added, across the two carriers with full negotiated-dollar books, and when reproduced in an independent hospital-reported data source.

The evidence indicates that the Wisconsin price premium is not driven by patient mix, insurer mix, hospital type, corporate identity, or service mix. Within the Advocate Health system, which operates on both sides of the border under common ownership, Wisconsin hospitals are still paid about 23 percent more than their Illinois counterparts. And the premium is strikingly uniform across the Blue plan and UnitedHealthcare, which independently land within half a percentage point of each other for inpatient care, a pattern difficult to reconcile with any single-insurer explanation. The pattern is instead consistent with a structural account tied to provider market concentration, system-level consolidation, and the strategic positioning of Wisconsin's major integrated health systems.

One structural feature of the Wisconsin market merits particular note, as it may be both a symptom and a mechanism of the pricing power documented here: the prevalence of percent-of-charge contracting. Under such a contract, a hospital is paid a fixed percentage of its own billed charges rather than a pre-negotiated dollar amount, which ties the effective price to a chargemaster that the hospital sets unilaterally and can raise over time. In the hospital-reported data, roughly 45 percent of Wisconsin inpatient rows are contracted this way, against about 24 percent in Illinois; for the three national commercial carriers the Wisconsin share exceeds 80 percent, while the dominant Blue plan—with by far the largest book of business—is a notable exception, consistent with the idea that only the largest payer can compel fixed pricing. Payers generally accept percent-of-charge terms only where they lack the leverage to insist on fixed dollars, so the concentration of such contracts in Wisconsin is consistent with the strong provider bargaining position that a consolidated hospital market confers; and because these contracts give hospitals a standing mechanism to raise realized prices, they may help entrench the very premium this report documents. We do not test this channel directly here—the primary estimate is built on fixed-dollar rates precisely to avoid it—but flag it as a hypothesis for the subsequent phases of this project, alongside the consolidation and vertical-integration dynamics that are its central focus.

Together, our findings highlight the need to engage policymakers, regulators, and stakeholders with a clear, data-driven account of the origins and consequences of Wisconsin's unusually high hospital prices.

Appendix A. Spending-share weights

The weighted analyses in Section 3 apply state-specific spend-share weights to each billing code, so that higher-spend services carry proportionally more weight within the analyzed subset. Because the reported analysis is inpatient-only, only the inpatient (MS-DRG) weights enter the estimates; these are listed in full in Table A1. Each weight is the code's share of commercial hospital spending across the analyzed high-spend code subset, computed separately for each state. The weights are applied as probability weights in the weighted least-squares specifications; because that estimator depends only on the relative magnitude of the weights, a common rescaling of all weights would leave every reported estimate unchanged.

Table A1: State-specific commercial spend-share weights for the inpatient MS-DRGs used in the analysis.

MS-DRG	Service	Illinois weight (%)	Wisconsin weight (%)
807	Normal Delivery	2.77	2.87
871	Septicemia or Severe Sepsis	1.89	2.42
003	ECMO	1.60	2.50
219	Cardiac Valve and Other Major Cardiothoracic Procedures	1.76	1.47
788	C-Section	1.52	1.52
025	Neurosurgery	1.32	1.56
853	Infections and Parasitic Diseases with O.R. Procedure	1.12	1.70
330	Other Digestive System O.R. Procedures	0.83	1.43
322	PTCA	1.04	1.10
787	C-Section	1.34	0.79
321	PTCA	0.88	1.15
329	Other Digestive System O.R. Procedures	0.71	1.01
270	Cardiovascular Surgery	0.66	0.80
189	Pulmonology	0.51	0.77
291	Cardiology	0.38	0.86
872	Septicemia or Severe Sepsis	0.58	0.62
233	Coronary Bypass	0.39	0.73
331	Other Digestive System O.R. Procedures	0.51	0.57
026	Neurosurgery	0.25	0.68
392	Esophagitis, Gastroenteritis and Misc Digestive Disorders	0.47	0.46
027	Neurosurgery	0.29	0.63
418	Cholecystectomy	0.33	0.28
065	Neurology	0.27	0.29
393	Other Digestive System O.R. Procedures	0.17	0.30
493	Orthopedic Surgery	0.18	0.19
274	Cardiovascular Surgery	0.11	0.23
All 26 inpatient codes		21.89	26.94

Weights are each code's share of state commercial hospital spending across the analyzed high-spend code subset (inpatient and outpatient combined). The 26 inpatient codes shown sum to 21.9 percent (Illinois) and 26.9 percent (Wisconsin); the balance corresponds to outpatient services, which are not used in the inpatient analysis. Multiple rows sharing a service description (for example, the neurosurgery and C-section codes) are distinct MS-DRGs that differ by severity or complication level. Rows are sorted by average weight across the two states.