

# The Source Roundup: July 2022 Edition

Happy Summer! We kick off the holiday weekend with the latest research and articles in healthcare price and competition. This month's Roundup highlights articles and reports that discuss 1) the impact and trends of private equity investment in health care; 2) compliance trends of the federal Hospital Price Transparency Rule; and 3) the role of high prices in excess healthcare spending in the U.S. and possible strategies for cost containment, including methods to limit costs and spending, such as 4) health savings accounts, 5) out-of-pocket spending limit for Medicare, and 6) applying Maryland's Total Cost of Care Model to other states.

## Competition and Consolidation

Private equity acquisitions have become a rising trend in health care. In a recent *Urology* article, [Association Between Private Equity Acquisition of Urology Practices and Physician Medicare Payments](#), James Nie, et al. studied private equity acquisitions of ten independent urology practices across six states. Focusing on the effects on Medicare payment and patient volume, they found that post-acquisition, urologists who joined private equity groups saw an 11% increase in Medicare payments and a 12.5% jump in patient volume. On the other hand, non-private equity affiliated urologists saw a 6% decline in Medicare payments along with a slight 2.7% increase in patient volume. Notably, the research indicated that even prior to the acquisition, urologists who later affiliated with private equity already experienced higher Medicare payments and patient volume compared to those urologists who did not. This finding may signify certain characteristics of physician practices that become targeted by private equity firms and may be meaningful given the growth of private equity in health care.

## Price Transparency

In 2021, the final rule of the federal Hospital Price Transparency went into effect. The rule aims to increase healthcare price transparency and facilitate patient price shopping by requiring hospitals to disclose 5 types of standard charges for all services and provide a consumer-friendly display for at least 300 shoppable services. In a recent JAMA Network research letter, [Adherence to a Federal Hospital Price Transparency Rule and Associated Financial and Marketplace Factors](#), Waqas Haque, et al. evaluated the compliance of 5239 total hospitals with the rule 6 to 9 months following the rule's effective date. They found that only 5.7% hospitals adhered to both rules. Notably, they found that certain types of hospitals had higher compliance, such as acute care hospitals with "lesser revenue per patient-day" in unconcentrated health care markets and urban areas. Given this trend, the authors conclude that greater scrutiny of hospitals without those characteristics are needed to ensure effectiveness of the transparency rule.

## Healthcare Prices and Cost Containment

It is common knowledge that healthcare spending has grown significantly in recent decades. A recent *Health Affairs* research brief, [The Role of Prices In Excess US Health Spending](#), suggests that high healthcare prices are a critical driver of excess health spending growth in the U.S., especially in the commercial sector. For example, the brief notes that spending per enrollee between 2015 and 2019 increased by 21.8 percent, and that rising service prices accounted for about two-thirds of the growth. However, the article notes that prices do vary widely among hospitals and between public and private insurers. Despite the variation, U.S. healthcare prices do not mirror, and are overall higher, than those in comparable countries. The article concludes by suggesting possible policy interventions to control excess health spending, such as 1) compliance with the transparency requirements of the Hospital Price Transparency rule, and 2) monitoring post-consolidation prices and setting maximum rates for hospitals in highly consolidated, noncompetitive markets.

To help contain healthcare costs and spending, health savings accounts (HSA) were

established to allow consumers to set aside money on a pre-tax basis to spend on future qualified healthcare expense. Though HSAs have been viewed as a way to help lower overall health costs, a recent *Health Affairs* article asserts that [Health Savings Accounts No Longer Promote Consumer Cost-Consciousness](#). Authors Sherry A. Glied, Dahlia K. Remler, and Mikaela Springsteen suggest that HSAs no longer achieve this expected cost-consciousness because cost sharing has increased so much in non-HSA-qualified plans and consequently argue that it is becoming more difficult to justify the tax break.

While HSAs may not be realizing expected cost-savings, an *Urban Institute* brief explores other methods to help contain healthcare costs. In [Adding Out-of-Pocket Spending Limit to Traditional Medicare](#), Anuj Gangopadhyaya, et al. analyze and discuss the implication of introducing a \$5,000 spending cap for traditional Medicare enrollees. Most private commercial plans, such as employer-based coverage, as well as Medicare Advantage, have out-of-pocket spending caps. The authors estimate that in 2023, 4.5 million traditional Medicare enrollees will average \$10,500 in cost-sharing expenses (paid by Medicaid, supplementary plans, and out-of-pocket by beneficiaries), thus a \$5,000 cap would significantly reduce cost-sharing payments. The authors argue that setting this initial cap would not only benefit Medicare high spenders, but all Medicare beneficiaries, since they would benefit from the reduced costs of supplementary insurance.

As healthcare costs and prices continue to rise, policy researchers are also exploring system-wide containment strategies. In the *Health Affairs* article, [Maryland Hospital All-Payer Model: Can it Be Emulated?](#), Troyen A. Brennan discusses the valuable insights states may consider from the decades-old Maryland Total Cost of Care Model (TCCM), which requires all-payer rate regulation, while hospitals operate under a prospective budget. Global budgets and uniform prices paid by the government and commercial insurers have been found to lower costs, improve quality, and create incentives for innovating care approaches to better care. Though the statistics of the Maryland program suggests it can be a model for other states, Brennan notes that Maryland is an outlier, in that there is a significant difference between Maryland hospital reimbursement and that of other states. Nevertheless, policymakers may look to Maryland's TCCM in their own health reform pursuits.

That concludes this month's Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way.