

# The Source Roundup: June 2023 Edition

In the past month, newly released publications have chronicled how partnerships, alternative payment models, and insurer market power affect competition and consolidation. Separately, researchers examined Affordable Care Act developments in terms of its impact on coverage and costs of health care. Moreover, as more and more price data are made publicly available, researchers studied how that data is presented, utilized, and what it reveals.

## Competition and Consolidation

Since 2005, over 190 rural hospitals have closed across the US, and today, 600 more (the nearly one third that remain) are dangerously close to the same fate. The federal government and some researchers had mused that partnerships among rural providers could be a solution to this phenomenon, because it can produce efficiencies and generate solutions to communal problems. Diving deeper into [How Regional Partnerships Bolster Rural Hospitals](#) for the *Commonwealth Fund*, Martha Hostetter and Sarah Klein assessed how critical access hospitals (CAHs) and other rural providers have created regional partnerships to overcome their challenges. The study noted several aspects of the partnerships that led to beneficial outcomes: sharing staff and expertise, pursuing more favorable contracts with payers, participating in value-based payment arrangements, promoting community development, and collaborating on areas with shared health and economic determinants. By joining together, member hospitals have been able to secure grant dollars, create local solutions, access value-based payment arrangements previously

unavailable, and increase the quality of care. The authors suggest that while regional health care partnerships will not solve all problems faced by rural providers, on balance, they are beneficial and point toward policy changes that can continue to bolster rural providers.

Writing for the *Health Affairs* Forefront series on Accountable Care for Population Health, Fang He asks [Have Alternative Payment Models Led to Provider Consolidation?](#). When the Affordable Care Act (ACA) was passed, many observers speculated that alternative payment models could lead to consolidation of health care providers and result in stifling competition between providers. However, over the past decade, evidence linking the rise of alternative payment models and expeditious consolidation of health care providers has been the subject of only a few studies that suggest a tenuous relationship. A 2017 study by Hannah Neprash and colleagues assessed the link between accountable care organizations (ACOs) and measures focused on provider consolidation and found only a weak connection between the two. Furthermore, a 2019 study by Genevieve Kanter and colleagues found that ACOs are linked to larger practices. Yet, while both studies found that ACOs and larger practices are linked, neither could establish causation, and it remains unclear whether ACOs lead to larger practices or vice versa. Similarly, the most recent study by He found no impact between an alternative payment model, Comprehensive Care for Joint Replacement (CJR) model, and provider consolidation. Ultimately, more studies are needed to ensure that alternative payment models do not lead to provider consolidation and increased health care costs.

Using data released by the Hospital Price Transparency initiatives, researchers from DePaul University (Anthony T. LoSosso, Kevin Toczydłowski, and Yanchao Yang) examined [Insurer Market Power and Hospital Prices in the US](#) to see how

concentration in the health insurance market affects negotiated prices paid to hospitals. Published in the latest issue of *Health Affairs*, their research found that the market-leading insurer in the least competitive (most concentrated) insurance markets pays 15 percent less to hospitals than the market-leading insurer in the most competitive (least concentrated) markets. Likewise, the study revealed the price relationship is more pronounced for for-profit hospitals than for not-for-profit hospitals. Overall, the results of this study confirmed previous work that found that greater insurance market concentration is linked with lower negotiated hospital prices and invites the question whether dominant insurers are passing savings on to employers in the form of lower premiums or retaining the savings in the form of higher profits. Given the rarity of insurer sided data, it is unclear at this stage how much and to what extent this affects providers; however, the authors noted that reverse causality is a possibility (e.g., lower payment rates to providers could be associated with lower premiums, and therefore higher insurer market share).

## **Healthcare Coverage and the Affordable Care Act**

As a result of the COVID-19 pandemic and policy responses, Medicaid and ACA Marketplace enrollment reached historic heights in 2023 and the Congressional Budget Office (CBO) estimates that the uninsurance rate will reach its lowest point in 2023 at 8.3 percent. However, this trend is likely to reverse as detailed in the *Health Affairs* article [Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-33](#). Caroline Hanson et al. analyzed the CBO's latest estimates for health insurance coverage for people under the age of 65 and noted that a reshuffle of coverage will occur over the next ten years due to the expiration of temporary

pandemic-related policies and, as a result, the uninsurance rate will rise to 10.1 percent by 2033. The two policies that have contributed the greatest to the growth of Marketplace enrollment are the 2022 Reconciliation Act that extended enhancement of Marketplace subsidies through 2025 and a 2023 regulation that extended eligibility for Marketplace subsidies to spouses and dependents of employees with access to employment-based coverage. However, as these policies expire, the CBO predicts a decrease in Marketplace enrollment and a shift in the distribution of coverage from 2023. As a result, the CBO's estimates that employment-based coverage will continue to be the largest source of health coverage with a monthly average enrollment between 155-159 million over the next ten years.

The constitutionality of the ACA requiring most private health plans to cover in-network preventive services at \$0 cost-sharing for enrollees is at the center of a legal challenge before the Fifth Circuit Court of Appeals. In *Braidwood Management v. Becerra*, the District Court in the Northern District of Texas ruled that preventive services recommended by the United States Preventive Services Task Force (see examples [here](#)) are excluded from the mandate. The Biden administration appealed the decision and the Fifth Circuit issued an administrative stay to temporarily pause the effect of the district court ruling. While some insurers and employers may introduce cost sharing down the line if the ruling is upheld, many major private health insurers announced they will not make any changes until a final ruling is made. In a report for the Peterson-KFF Health System Tracker, Krutika Amin et al. examined the [Use of ACA Preventive Care Potentially affected by \*Braidwood v. Becerra\*](#). The analysis showed that over 5%, or nearly 10 million people, of privately insured people received some type of ACA preventive services or drugs that could be subject to higher out-of-pocket costs if the ruling stands and insurers decide to implement cost-sharing.

Notably, the study relied on 2019 data that did not capture colorectal cancer screenings or pre-exposure prophylaxis (PrEP) because the recommendation for these came later. Moreover, the ruling can also have a more significant effect in the present and future because it would exclude new preventive services and drugs that are developed, recommended, and adopted.

## **Price Transparency and Data Utilization**

Two recent *Health Affairs* Forefront pieces on Provider Prices in the Commercial Sector focused on price transparency and how public pricing data can be used to benefit consumers.

In [The Health Plan Price Transparency Data Files are a Mess—States Can Help Make Them Better](#), Sabrina Corlette discussed how insurance regulators can go beyond merely confirming that insurers are complying with price transparency requirements by ensuring that the data files are published in a manner that meets their goals to constrain health care cost growth and improve affordability for consumers. Corlette argues that state efforts to constrain costs and improve affordability of coverage could benefit from access to robust, real-time, and provider-specific information about the prices that insurers are paying. This data could in turn support market scanning, new initiatives to constrain cost growth, antitrust enforcement, purchasing alliances, independent dispute resolution for out-of-network billing, and rate review. However, at the moment, these data remain inaccessible and unusable, but the potential could be unlocked through state-federal partnership to improve data access and quality.

Similarly, in [Using Publicly Available Health Plan Pricing Data for Research and App Development](#), Daniel Cullen et al. discussed how price transparency requirements by the Centers for Medicare

and Medicaid Services (CMS) can be used to conduct research or create tools for consumers to price shop. Using colonoscopy procedure as a test case, the study revealed that a single provider can have multiple prices for the same procedure and that place of service can have a large impact on prices. For example, 98.5 percent of claims occur in either campus-outpatient hospitals or ambulatory surgical centers, yet prices are lower at the latter despite the higher number of prices negotiated in the outpatient hospital setting. While price transparency data advances the understanding of health care prices by allowing for comparison across payers, there are limitations in the CMS-mandated layout which either fails to capture aspects of institutional and professional contractual structure or does not capture them in detail.

## **Prescription Drug Prices**

According to a perspective article published in the *New England Journal of Medicine*, the factors driving the sudden decrease in insulin prices are due to a combination of long-standing public shaming, market forces and recent regulations. [In Falling Insulin Prices—What Just Happened?](#), Dr. Leemore S. Dafny charted the latest developments behind the precipitous drop in insulin prices. Beginning in July 2021, the first major development that spurred the decline in insulin prices was the FDA approval of Semglee, a product that is interchangeable with Sanofi's Lantus. Then, in 2022, three more significant changes occurred: 1) nonprofit drug company Civica announced plans to develop and sell three insulin biosimilars at a maximum price of \$30 per vial by 2024, 2) California approved a plan to develop their own brand of low-cost, interchangeable biosimilar insulins, and 3) Congress, as part of the Inflation Reduction Act, capped insulin copayments at \$35 per month for each product covered by

Medicare. The momentum continued in 2023, when Eli Lilly announced in March that they will begin to cap out-of-pocket costs at \$35 for some of its older insulin products. Following Eli Lilly's footsteps, both Novo Nordisk and Sanofi announced similar price cuts and out-of-pocket monthly caps. Overall, reductions in insulin prices can be attributed to increased competition, government regulation, and public shaming. However, while pleased with the outcome, Dr. Dafny warned that Americans will likely continue to pay higher prices for new drugs unless multifaceted efforts can be sustained.

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.