The Source Roundup: May 2022 Edition

This month in The Source Roundup, we cover articles and reports that examine: 1) the effect of private equity acquisition of hospitals; 2) the latest trends on hospital prices; and 3) ACA marketplace premiums at the state level in the last 3 years. Additionally, we highlight several cost containment strategies studied in recent reports, including 4) a progressive taxing proposal co-authored by The Source team, 5) establishing a state cost commission in California with lessons from other states, and 6) purchaser-led efforts to reduce healthcare costs.

Consolidation and Competition

On the topic of consolidation and competition, Marcelo Cerullo, et al. report on financial performance of short-term acute care hospitals after private equity acquisition in the new *Health Affairs* article Financial Impacts and Operational Implications of Private Equity Acquisition of US Hospitals. The authors analyze changes in 176 hospitals' financial performance from 2005 to 2014. Overall, financial performance of these hospitals improved after the acquisition, but markers of hospital capacity and staffing metrics did not. Specifically, private equity acquisition of a hospital saw an average of $432 decrease in cost per adjusted discharge and a 1.78% increase in operating margin. At the same time, private equity acquisition was found to be associated with decrease in total beds and staffing, increased inpatient utilization, and decreased ratio of outpatient to inpatient charges.

Healthcare Prices and Premiums

Fair Health's key findings in FH® Healthcare Indicators and FH® Medical Price Index report that hospitals have increased prices for initial hospital care and emergency room visits more than other types of care. Out of the six hospital procedure categories studied, professional evaluation and management (E&M) had the greatest percent increase in charge amount index (seven percent) and negotiated rates (five percent). The report also highlights an immense growth in telehealth service, which increased by 41,919 percent from 2015 to 2020. On the other hand, utilization decreased between 2019 to 2020 for all other healthcare facilities studied. Among all the places studied, telehealth has the highest percentage of medical claim lines in 2020. More medical claim lines were submitted for females than males, but the gap was narrower in some places like retail clinics, urgent care clinics, ambulatory surgery centers, and emergency rooms.

Hospital prices paid by private health plans varied by different geographic regions in the U.S, according to a new *Health Affairs* article. In Trends in Hospital Prices Paid by Private Health Plans Varied Substantially Across the US, RAND researchers Zachary Levinson, Nabeel Qureshi, Jodi L. Liu, and Christopher M. Whaley found commercial health plans pay higher prices than public payers for hospital services. Data from the Healthcare Provider Cost Reporting Information System from 2012 to 2019 shows hospital prices for commercial health plans in 2012 averaged 173% of what Medicare was paying. Additionally, while average commercial-to-Medicare price ratios were mostly stable, trends varied greatly across hospital referral regions (HRRs). In particular, the study shows that California dominates the 19 regions that saw the highest growth in hospital prices paid by private insurers, with 11 regions that made the list. Moreover, out of the 11 regions in California, eight were in Northern California, revealing consolidation effects which has increased antitrust scrutiny on systems with market power like Sutter Health.

In the latest Urban Institute report Marketplace Competition and Premiums, 2019–2022, John Holahan, Erik Wengle, and Claire O'Brien examine Affordable Care Act (ACA) marketplace premiums at the state and rating region levels. In that period, the researchers found that premiums fell around the country, with a decrease of 1.8 percent in national average benchmark premiums between 2021 and 2022. By comparison, there was a premium increase of four percent in the employer-sponsored insurance market over the same period. The national average contradicts the variation of premiums across and within states. The variation is most affected by higher unemployment rates due to Covid-19 and by the types and numbers of insurers participating in a rating region, which increased from 198 to 288 between 2020 and 2022 in the 58 regions explored in the report.

Cost Containment

High healthcare costs adversely affect patients with delays in necessary care, decreases in wage growth, increases in federal spending that could lead to higher taxes, and increases in disparities in healthcare access. While state policy makers focus on regulations that would restore healthcare competition and force prices down, The Source's Katherine L. Gudiksen and Jaime S. King, along with co-author Darien Shanske, discuss Can Taxes Help Address High Health Care Prices? In this new piece for *Health Affairs*, the authors argue that taxation can be a more-targeted tool to lower healthcare costs and propose a progressive tax on provider rates. The proposal would tax excessive provider prices but adjust for market differences such as certain rural hospitals and only apply in highly concentrated markets. The proposal also considers possible legal challenges and acknowledges the exact tax rate would be achieved through an iterative process.

In California, healthcare premiums have grown by 300 percent

in the last 20 years. The state has proposed to establish a new Office of Health Care Affordability (OHCA) to monitor and address rising healthcare costs. In Health Care Cost Commissions: How Eight States Address Cost Growth published by the California Health Care Foundation, Glenn Melnick examines other states' healthcare cost commissions and identifies six key universal components from those cost commissions that California could learn from. Melnick specifically looks at how the eight state cost commissions (1) establish authority for the program, (2) establish a governance body and administrative infrastructure, (3) set targets for cost growth and delivery system reform, (4) collect data to measure and monitor cost growth at the payer level, (5) collect necessary data at the subpayer level to identify and analyze cost drivers, and (6) develop and implement strategies and procedures to enforce targets. Additionally, the report discusses other important factors that could ensure greater effectiveness of California's potential healthcare cost commission, including greater transparency around spending trends and cost drivers, inclusive stakeholder processes around challenges and opportunities, and broad authority for enforcement.

In a Commonwealth Fund report, Sarah Klein focused on purchaser-led efforts to reduce rising healthcare costs. According to Tackling High Health Care Prices: A Look at Four Purchaser-Led Efforts, U.S. employers have failed in their efforts to reduce prices they pay for employees' health insurance benefits, partly because they lack enough employees to make changes in local markets. Some employers lack sufficient negotiation tactics, while others avoid asking employees to change how they receive their care. Resultantly, employees' costs rise as employers shift cost burdens onto them. The author analyzes four purchaser-led initiatives to reduce costs, including direct negotiations with health care providers, employee incentives to seek care from higher-quality, lower-cost providers, and transparency efforts to

call attention to high prices. Klein concludes that transparency of medical claims data is “paramount” and that employers should partner and align their interests with other stakeholders, including the government, in order to scale these strategies to gain leverage in healthcare markets that lack competition. Finally, the author acknowledged that greater widespread change may require policy reform, such as legislation to bar anticompetitive contract terms, capping prices for out-of-network care, and establishing a national all-payer claims database (APCD).

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.

Health Care Cost Commissions: How Eight States Address Cost Growth

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HB 317

An Act to amend Title 31 of the Delaware Code relating to medical coverage for all Delaware children.

HB 234

An Act to Amend Title 31 related to extension of Medicaid coverage through the first year postpartum.

HB 219

An Act to amend Title 18 of the Delaware Code relating to pharmacy benefits managers.

HB 160

An Act to amend Titles 18 and 24 of the Delaware code relating to preserving telehealth and adopting the interstate medical licensure compact.

HB 62

An Act to amend Title 6 of the Delaware code relating to the prohibition of excessive and unconscionable prices for prescription drugs.

SB 109

An Act to amend Title 29 of the Delaware Code relating to Medicaid reimbursement rates for home health-care services.

SB 128

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE DELAWARE HEALTH INFORMATION NETWORK CHAPTER.

SB 120

This Act is a substitute for Senate Bill No. 120. Like Senate Bill No. 120, this Substitute continues recent efforts to strengthen the primary care system in this State by doing the following:

(1) Directing the Health Care Commission to monitor compliance with value-based care delivery models and develop, and monitor compliance with, alternative payment methods that promote value-based care.

(2) Requiring rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services, to certain percentage increases.

(3) Requiring an insurance carrier to spend a certain

percentage of its total cost on primary care.

(4) Requiring the Office of Value-Based Health Care Delivery to establish mandatory minimums for payment innovations, including alternative payment models, and evaluate annually whether primary care spending is increasing in compliance with the established mandatory minimums for payment innovations.

(5) In Sections 2 and 3 of this Act, revising the appointment process for members of the Primary Care Reform Collaborative who are not members by virtue of position to comply with the requirements of the Delaware Constitution. These revisions are largely similar to those proposed in Senate Substitute No. 1 to Senate Bill No. 59 (151st General Assembly) ("the Substitute"). As such, Section 2 is designed to take effect if the Substitute does not pass both chambers or passes but is not enacted; Section 3 is designed to take effect if the Substitute passes both chambers and is enacted.

(6) Making technical corrections to conform existing law to the standards of the Delaware Legislative Drafting Manual

This Substitute differs from Senate Bill No. 120 as it does all of the following:

(1) Adds a "whereas clause" stating that the Department of Insurance does not regulate Medicaid or employer-based plans provided under the Employee Retirement Income Security Act, or their rates.

(2) Provides that rate filings for health benefit plans may not include aggregate unit price growth for nonprofessional services that exceed the greater of 2% or Core CPI plus 1% in 2024, 2025, and 2026.

(3) Makes a technical correction to properly alphabetize definitions in Section 4 of the Act (relating to § 2503 of Title 18).

(4) Removes “mental health and substance abuse disorder” from the definition of an “inpatient hospital”.

(5) Adds a definition of “professional services” and makes clear that “nonprofessional services”, which are subject to the aggregate unit price growth limits of § 2503(a)(12)a. of Title 18, do not include professional services.

(6) Amends the definition of “other medical services” to make clear the term includes the facility component of vision exams, dental services, and other services when those services are billed separately from the professional component.

(7) Changes the date for mandatory minimums for payment innovations to support a robust system of primary care to January 1, 2026.

(8) Make clear that the Office of Value-Based Health Care Delivery is to annually evaluate whether primary care spending is increasing in compliance with the requirements of, and regulations adopted under, all of Title 18.

(9) Requires the Office of Value-Based Health Care Delivery to collect data and develop reports to monitor and evaluate the percentage of spending in primary care that is delegated to hospitals and related networks for care coordination through alternative payment models.

(10) Removes the sunset date on provisions requiring individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate.

(11) Sunsets Sections 5 and 6 of this Act and § 2503(a)(12)a. of Title 18 as contained in Section 4 of this Act on January 1, 2027.