What Is Driving Health Care Spending Upward In States With Cost Growth Targets?

The Clearest Road To An ACA Public Option Runs Through The States

---

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

The Source Roundup: April 2022 Edition

This month, we are pleased to highlight new publications co-authored by The Source-affiliated health policy researchers and scholars, discussing 1) the potential benefits of all-payer hospital global budgets, and 2) the legal viability and policy effects of state public option health plans. Additionally, we examine articles covering research on 3) hospital service offerings based on ownership type, 4) the correlation between hospital prices and patient outcomes, 5) data sources within California's physician practice landscape, and 6) the labor market impact of hospital mergers.

Healthcare Reform and Cost Containment

High healthcare prices and rising market concentration have led to a range of proposals to regulate hospital prices. In the issue brief "Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending" for the Commonwealth Fund, Robert Murray, a Source-affiliated Senior Health Policy Researcher, looks at government-administered and

-regulated pricing systems as a potential solution for states to consider. After reviewing literature and analyses of past and existing pricing systems, Murray determined that an all-payer hospital global budget, in which revenues are capped for a specified period for all services provided to patients, could help remove fee-for-service incentives that induce hospitals to provide unnecessary and low-value care, while at the same time giving states a tool to effectively constrain hospital expenditure growth for all payers. Another benefit of a global budget arrangement is that such a payment system is less complex than systems that set explicit prices or price caps for every service. Overall, Murray shows how hospital global budget arrangements can create the conditions necessary to hold hospitals accountable for the costs of services they provide while emphasizing the policy objective of cost containment.

After publishing in the New England Journal of Medicine, the research article "Are State Public Option Health Plans Worth It?", co-authored by The Source's Katie Gudiksen and Jaime King, along with Erin C. Fuse Brown, was recently published in the Harvard Journal of Legislation. The article evaluates and provides a comprehensive survey and taxonomy of state public option proposals from 2010-2021, including legislation advanced in Washington, Colorado, and Nevada, identifying three basic models: 1) Medicaid buy-in public options; 2) marketplace-based public options; and 3) comprehensive public options. In this paper, the researchers try to quantify whether such plans are worthwhile and legally viable for states. The answer, the authors write, is yes to both. Surprisingly though, the legal viability and policy effects increase with the scope of the plan. In other words, with state public option plans, bigger is better. Ultimately, the article shows that despite legal and fiscal hurdles to state health system reforms, states developing public options may offer the federal government important policy design lessons in expanding access to care at a lower cost.

Provider/Hospital Services

Over fifteen years ago, health policy researcher Jill R. Horwitz demonstrated that nonprofit and for-profit hospitals offered different mixes of services, with the differences depending on the services' relative profitability. Since then, the Affordable Care Act (ACA) has led to dramatic changes in health care financing and delivery. In a new *Health Affairs* article, Hospital Service Offerings Still Differ Substantially By Ownership Type, Horwitz and Austin Nichols consider whether nonprofits still differ meaningfully from for-profits in their role as medical service providers, and find results similar to those they found before the ACA health reform. Their study found that compared to their nonprofit and government counterparts, for-profit urban hospitals are significantly less likely to offer and pursue care services that don't turn a profit. Similarly, these for-profits were more likely to offer profitable care service lines than facilities with nonprofit or government ownership, although all three groups, on average, were more likely to offer any given profitable service than an unprofitable service. Moreover, nonprofit and government hospitals alike were more likely to offer any given service, on average, due to their larger size. While nonprofits often receive criticism for not doing enough to justify their tax-exempt status, the researchers argue that it's also important to evaluate what services hospitals offer when gauging whether nonprofits earn their tax exemptions.

In another article studying hospital services, researchers examine the correlation between prices and quality. Higher prices generally imply increased quality in most consumer markets, but health prices and health quality can be difficult to interpret. A working paper from the National Bureau of Economic Research challenged the assumption that higher prices translate to better quality of care. In "Do Higher-Priced Hospitals Deliver Higher-Quality Care?", Zack Cooper, Joseph

J. Doyle Jr., John A. Graves, and Jonathan Gruber consider whether patients get better health outcomes when they are treated at higher-priced hospitals and explore how the relationship between providers' prices and quality varies in concentrated and unconcentrated hospital markets. Within this context, the researchers conducted a study to analyze whether receiving care from higher-priced hospitals leads to lower mortality. Their findings showed that getting care from higher-priced hospitals in an emergency doesn't necessarily result in better outcomes – at least in markets that have little competition. The study found that mortality rates decreased in hospitals with higher prices in only unconcentrated markets, while no correlation was observed with hospitals in concentrated markets. In concentrated markets, high prices likely reflect patients' lack of choices in getting care, not hospital quality. The researchers conclude that more vigorous antitrust enforcement can lead to more efficient outcomes in markets where competition is geographically possible.

Aside from hospitals, physician practice has understandably drawn scrutiny from policymakers with such services accounting for 20% of total health care spending, the second-largest category behind hospital care (31%). A recent California Health Care Foundation report describes California's physician practice landscape and specifically sheds light on the significant gaps in information about the state's physician services market. In "California's Physician Practice Landscape: A Rapidly Changing Market with Limited Data", Jill Yegian and Marta Green explain that existing sources on the structure, characteristics, and financing of physician practices are piecemeal and often not publicly available. In addition, lack of shared definitions and language about the structure and characteristics of physician practices can create confusion, further complicated by the variation in contractual relationships and payment arrangements between payers and providers. The authors address these challenges by

reviewing available information sources on the physician practice landscape in California, with a focus on existing regulatory and reporting requirements. Further, their paper begins to create common language and terminology about physician practices and organizations with the goal of enabling a more substantive discussion of relevant policy issues, including gaps in currently available information and prospects for new accountability measures. Addressing the physician market from a policy perspective, the report shows how healthcare policymakers could benefit from enhanced data access and accountability.

Effects of Healthcare Consolidation

Antitrust investigations into hospital mergers have mainly focused on whether mergers lead to anticompetitive behavior that may limit patient access to care or raise prices for services. While there is significant research showing that hospital mergers raise prices, little work has been done on the broader ramifications of hospital consolidation on the labor market. A new study, "Employer Consolidation and Wages: Evidence from Hospitals", examines the impact of hospital consolidation on employee wages. Writing for the American Economic Association, Elena Prager and Matt Schmitt demonstrate that mergers that significantly increased hospital concentration in the local labor market slowed wage growth for workers whose employment prospects were closely linked to hospitals. Certain types of hospital mergers causally decrease wages for certain healthcare workers, according to the report's citation of research published in the American Economic Review in February 2021. Hospital mergers that cause the largest gains to hospital concentration under the Herfindahl-Hirschman Index (HHI), which measures market concentration, cause wage growth to slow for skilled workers, nurses, and pharmacy workers. The article's findings support the idea that merging hospitals can gain labor market power

over some categories of workers and suggest that labor market considerations may be a warranted addition to the antitrust merger review criteria used to identify mergers with potentially detrimental impacts.

Prager and Schmitt's study also corroborates findings from the U.S. Treasury Department's latest report on competition in the labor market. The report, "The State of Labor Market Competition in the U.S. Economy," describes in its hospitals and nurses subsection how hospital consolidation can negatively impact nurses. "When the hospital industry consolidates by closing hospitals, it increases monopsony power mechanically by increasing the cost among nurses to find work elsewhere (i.e., longer commutes)," according to the report. "Even when consolidation does not reduce the number of hospitals (e.g., through a merger of hospital systems) it can increase the monopsony power by reducing competition among the remaining firms." The report concludes with a forward-looking policy agenda to increase labor market competition, ranging from renewed antitrust enforcement to progressive legislation.

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.

Update on State Public

Option-Style Laws: Getting to More Affordable Coverage

Are State Public Option Health Plans Worth It?

Just Published in Harvard Journal on Legislation: Are State Public Option Health Plans Worth It?

In a new paper published in the Harvard Journal on Legislation Volume 59, Issue 1, The Source's Jaime King and Katie Gudiksen, together with Erin Fuse Brown, discuss state public option proposals from 2010–2021, including from states like Nevada, Colorado, and Washington. In examining the three main models–(1) Medicaid Buy-In Public Options; (2) Marketplace-Based Public Options; and (3) Comprehensive Public Options–the paper considers potential challenges to these state public option plans and whether they are legally viable and "worth it" for states to pursue, given the goal of improving healthcare coverage and affordability. Read the paper here.

Also listen to a podcast for the New England Journal of

Medicine in which co-author Erin Fuse Brown discusses lessons from the states public option plans explored in the paper.

Nevada moves forward with low-cost drug program

Other States Keep Watchful Eye on Snags in Washington’s Pioneering Public-Option Plan