The Source Roundup: April 2024 Edition

Healthcare System Mergers and Investments

Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21 (*Health Affairs*)

Ola Abdelhadi, Brent D. Fulton, Laura Alexander, and Richard M. Scheffler

The awareness for private equity's influence on the healthcare sector continues to grow and be quantified. Generally, there has been concern among parties in the health care system regarding the rate at which private equity firms have been acquiring physician practices, creating antitrust, quality, and pricing concerns within the broader health system. A new *Health Affairs* study estimated the local market share of private equity firms within ten physician specialties at the Metropolitan Statistical Area (MSA) level and found that private equity-acquired physician practices increased from 816 across 119 MSAs in 2012 to 5,779 across 307 MSAs in 2021. Single private equity firms were found to hold significant market share reaching as high as over 50% in some MSA specialty markets. The authors use this paper to call out to the FTC, state regulators, and policy makers to apply closer scrutiny over these acquisitions.

Health System Transformation

Vertical Integration and the Transformation of American Medicine (*The New England Journal of Medicine*)

Dhruv Khullar, Lawrence P. Casalino, and Amelia M. Bond

Over the past decade, the United States has seen a significant rise in the acquisition of physician practices by hospitals, which has led to a substantial number of physicians becoming hospital employees. Such arrangements can have meaningful impacts on both the quality and cost of healthcare. While vertical integration is assumed to have benefits such as improved patient outcomes through improved care coordination, research has shown that the primary effect has been increased health care prices due to the strong negotiating power of these institutions. In a new opinion piece in the *New England Journal of Medicine*, the authors dive deeper into this topic and discuss the FTC and DOJ's updated antitrust guidelines concerning market concentration and competition. While gradual changes are being made, the authors call for further research to be pursued on the consequences of the acquisitions of physician practices by hospitals. The authors suggest that the key to relieving the ongoing tension between healthcare integration and competition requires us to improve our understanding of the implications of these acquisitions on all interested parties.

The Effect of Health-Care Privatization on the Quality of Care (*The Lancet*)

Benjamin Goodair and Aaron Reeves

Over the past four decades, many global healthcare systems have shifted from public ownership to privatization by

outsourcing health care services to the private sector. The rationale behind these shifts have often been to enhance the quality of care through increasing competition and promoting patient-centered approaches. However, researchers from the University of Oxford recently challenged these assertions. This study describes the findings of a meta-analysis which reviewed literature on the trend towards privatization, specifically focusing on high-income countries. The study found that that shifting towards private ownership tended to create higher profits through the selective intake of patients and reductions to staff numbers but was simultaneously correlated with worse health outcomes for patients. Better knowledge regarding the effects of healthcare privatization can help policymakers to make better decisions regarding healthcare delivery and ensure that patients don't get left behind during system reforms.

Healthcare Cost and Spending

Trauma Center Hospitals Charged Higher Prices for Some Nontrauma Care Than Non-Trauma Center Hospitals, 2012–2018 (*Health Affairs*)

Daniel P. Kessler, Richard Sweeney, and Glenn A. Melnick

Rising hospital prices have been the largest driver of rising health care prices, which have subsequently also led to an increase in health care spending and insurance premiums. While trauma center hospitals offer both trauma and non-trauma services, they hold a unique position because they often maintain a monopoly over trauma services in certain areas. A new study published in *Health Affairs* looked into how trauma center-designation affected the price of of nontrauma services. Researchers concluded that trauma centers often charged higher prices for nontrauma

inpatient admissions and emergency department visits when compared with non-trauma centers. Understanding the drivers of price could provide important insights for policymakers and experts to consider when trying to tackle continuing health care and insurance pricing issues.

Payer Type and Emergency Department Visit Prices (*JAMA Open Network*)

Jacob R. Morey, Richard C. Winters, Aidan F. Mullan, John Schupbach, and Derick D. Jones

Health care costs pose a financial barrier for many U.S. residents, particularly due to the lack of price transparency that prevents patients from shopping around and negotiating rates. A new study in *JAMA Open Network* investigated the transparency and variation in pricing for emergency department visit facility fees. Researchers used datasets from hospitals who were compliant with the Center for Medicare and Medicaid Services' (CMS) Hospital Price Transparency rule to compare list prices, cash prices, and negotiated rates for ED Visits across varying medical decision-making levels. They found that Managed Medicaid rates were consistently the lowest, followed by Medicare Advantage rates, cash prices, and private insurance rates. Overall, they also found that hospital rating and size were associated with higher prices and rates. These findings indicate significant variation in pricing structures across payers which holds implications for healthcare policy, reimbursement model and cost reform.

Congress Has the Opportunity to Deliver Health Care Price Transparency (*Health Affairs Forefront*)

Christopher M. Whaley, Jared Perkins, and Ge

Bai

A new article in *Health Affairs Forefront* zeroes in on the growing frustration among patients and employers over the lack of transparency in U.S. healthcare pricing when purchasing health benefits. This article is the latest in *Health Affairs Forefront's* series on Provider Prices in the Commercial Sector, which discusses and assesses physician, hospital, and other health care provider prices in the private-sector markets and their contributions to overall spending. Authors discuss how bipartisan efforts in Congress have aimed to strengthen transparency rules by pushing hospitals and insurers to enhance price transparency with bills like the Lower Costs, More Transparency Act, and the Health Care PRICE Transparency Act 2.0. While both bills require disclosures of negotiated rates and cash prices for services, with penalties for noncompliance, the authors note continuous concerns regarding data accuracy and the effectiveness of some provisions with watered down language. Ultimately, the authors note that despite its criticisms, expanded price transparency has the potential to empower consumers, promote competition, and improve healthcare affordability and quality.

Accountable Care Organizations

Update on the Medicare Value-Based Care Strategy: Alignment, Growth, Equity (*Health Affairs Forefront*)

Douglas Jacobs, Purva Rawal, Michelle Schreiber, Dora Lynn Hughes, Elizabeth Fowler, and Meena Seshamani

Medicare plays an arguably significant role in transitioning the U.S. healthcare system towards value-

based payment models which prioritizing quality and efficiency. This new article is the latest in *Health Affairs' Forefront* series on Accountable Care for Population Health, which has sought to understand, design, support, and measure patient-centered, cost-efficient accountable care. The authors discuss the Centers for Medicare and Medicaid Services' (CMS) strategy on alignment, growth, and equity to drive this transition towards value-based payment models. Among CMS' priorities, the organization is attempting to have broad participation in accountable care organizations (ACOs) by 2030, addressing health disparities through value-based models in in underserved communities, enhancing data sharing, and incentivizing providers to address the social determinants of health. CMS' strategy represents a commitment towards high-quality, equitable, and accountable care within the Medicare system which may, in turn, create broader impacts on the adoption of value-based practices throughout the American healthcare system.

Measuring Value in Healthcare: Lessons from Accountable Care Organizations (*Health Affairs Scholar*)

Chenzhang Bao and Indranil R. Bardhan

Accountable care organization (ACO) programs consist of groups of physicians, hospitals, and health care providers who jointly provide coordinated, patient-focused care. Despite existing for over a decade, few conclusions have been drawn regarding the value of the care that is delivered by ACOs. In this new study, researchers assessed the value of ACO organizational characteristics and the social determinants of health (SDOH) using a novel measure of healthcare value by using data envelopment analysis. Among their findings, the researchers concluded that the value of ACOs has stagnated in recent years and suggest

that ACOs should strive for a "skinny in scale, broad in scope" approach to improve the future value of ACOs. Ultimately, the findings suggest that ACOs should be incentivized to work with local communities and enhance care coordination for vulnerable patient populations.

Health Policy Trends

Changes in Health Care Workers' Economic Outcomes Following Medicaid Expansion (*JAMA Network*)

Sasmira Matta, Paula Chatterjee, and Atheendar S. Venkataramani

There has been limited information regarding the ways in which changes in health sector finances impact economic outcomes among health care workers, especially lower-income workers. Researchers in a new study published in *JAMA Network* sought to understand whether health care workers benefited from improved health sector finances. Specifically, they sought to understand the association between state adoption of the Affordable Care Act's Medicaid expansion and health care workers' annual incomes and benefits. Medicaid expansion was associated with higher incomes but only among those who were in higher-earning occupations. This finding indicates that improved health sector finances may expand economic inequality among health care workers of varying income levels.

The Impact of Scope-of-Practice Restrictions on Access to Medical Care (*Journal of Health Economics*)

Jiapei Guo, Angela E. Kilby, and Mindy S. Marks

Opioid use disorder differs from other drug use disorders because it is treatable with the use of medications such as

methadone, buprenorphine, or naltrexone. A new study published in the *Journal of Health Economics* assessed the impact of scope-of-practice laws in the provision of medication assisted treatment (MAT) for opioid use disorder. Researchers considered two natural experiments generated by policy changes at the state and federal levels which allowed nurse practitioners increased practice autonomy and prescribing power. They concluded that both experiments indicated that liberalizing prescribing authorities led to larger improvements in access to care. Specifically, they suggest that expanding the prescribing authority of nurse practitioners could serve to reduce urban-rural disparities in health care access and could also increase access to care provided by physicians.

Implications for Public Health Regulation if *Chevron* Deference is Overturned (*JAMA*)

Sahil Agrawal, Joseph S. Ross, and Reshma Ramachandran

The legal community has been buzzing with speculation ever since the U.S. Supreme Court heard oral arguments on January 17, 2024, for a case that will ultimately decide the fate of *Chevron* deference in the U.S. *Chevron* deference is a longstanding administrative law principle that requires courts to defer to agencies' reasonable interpretations of ambiguous statutes. In this new *JAMA* article, the authors argue that regulatory agencies like the FDA and CMS may soon be limited from using their expertise to interpret public health statutes. The Supreme Court's final ruling, which is expected to be released this summer, could have significant implications for medicine and public health, ultimately affecting the ability of agencies to issue informed and responsive regulations. Overturning *Chevron* could lead to increased legal challenges and uncertainties, which may thereby inhibit

agencies' abilities to enforce regulatory standards. The authors argue that this trend could ultimately chip away at the public's trust in scientific institutions and impede efforts to address emerging and existing public health challenges.

Pharmaceutical Costs and Competition

Prescription Drug Dispensing and Patient Costs After Implementation of a No Behavioral Health Cost-Sharing Law (*JAMA Health Forum*)

Ezra Golberstein, James M. Campbell, Johanna Catherine Maclean, Samantha J. Harris, Brendon Saloner, and Bradley D. Stein

On January 1, 2022, New Mexico implemented a new law that eliminated cost-sharing for mental health and substance use disorder (MH/SUD) treatments in state-regulated plans, and was thought to potentially reduce a barrier to the commercially insured. A new study in *JAMA Health Forum* sought to investigate this question further, by specifically looking at whether out-of-pocket spending and dispensing of prescription drugs changed after the law was implemented. Researchers assessed prescription data from 47,229 individuals using a difference-in-difference analysis to examine dispensing and cost data for MH/SUD medications. They found that the behavioral cost sharing law was associated an 85.6% reduction in patient spending per medication while the volume of medications dispensed was unchanged. The authors argue that New Mexico's law suggests that cost-sharing for MH/SUD treatments can greatly reduce patient spending on medications.

HB 165

An act relating to pharmaceutical drugs; requiring Medicaid managed care organizations to reimburse community-based pharmacy providers for the full cost of prescription drugs plus a professional dispensing fee; requiring the health care authority department to conduct a study to determine and set a reasonable professional dispensing fee for pharmacy providers that provide services to medicaid recipients

SB 14

An act relating to insurance; amending and enacting sections of the pharmacy benefits manager regulation act; adding new requirements for renewal of pharmacy benefits manager licenses; requiring disclosure of documents during an investigation; requiring transparency in pharmacy benefits reimbursement; providing for confidentiality; providing for changes in the reimbursement process; addressing the appeals process; requiring the provision of certain information upon request; requiring the inclusion of certain contract provisions; limiting charges to those itemized in a contract; addressing cost sharing; making an appropriation.

SB 146

An act relating to hospitals; enacting a new section of the hospital funding act to provide affordable payment plans to patients under certain circumstances.

HB 306

Relating to hospitals; requiring financial transparency reports from corporations doing business in New Mexico as hospitals or providers of management services for hospitals that seek the benefit of monetary caps on damages provided by New Mexico law; requiring the superintendent of insurance to publish reports; making an appropriation.

HB 33

Relating to prescription drugs; enacting the prescription drug price transparency act to increase transparency across the prescription drug supply chain; requiring prescription drug manufacturers, pharmacy services administrative organizations, health insurers and pharmacy benefits managers to report prescription drug price trends to the superintendent of insurance; requiring the superintendent of insurance to collect and publicly report aggregate information on prescription drug price trends; prescribing civil penalties; making an appropriation.

SB 15

Relating to insurance; enacting the health care consolidation oversight act; requiring review of proposed health care mergers, acquisitions and other material changes in control of health care entities, including health insurance entities; providing exceptions; granting the office of superintendent of insurance and the health care authority department the authority to review proposed transactions; providing for public comment and stakeholder advisory committees; authorizing the approval, disapproval or conditional approval of transactions; protecting confidentiality of trade secrets; assessing costs; providing post-transaction oversight; prescribing a penalty; declaring an emergency.

SB 17

Relating to health care; enacting the health care delivery and access act; imposing on certain hospitals the health care delivery and access assessment; creating the health care delivery and access fund; creating the health care delivery and access medicaid-directed payment program; providing that revenue from the assessment be used as additional reimbursement to certain hospitals; providing a distribution to the health care delivery and access fund; providing that the tax administration act applies to and governs the health care delivery and access act; providing a delayed repeal; providing a contingent effective date; making an appropriation.

In An Era Of Premium And Provider Price Increases, State Employee Health Plans Target Key Cost Drivers

State Public Option Plans Are Making Progress on Reducing Consumer Costs