This month in health policy research, surprise billing and changes in market structures fuel concerns about competition and consumer choice. In addition, some studies on pharmaceutical costs produced hopeful reports.

Healthcare Market Competition and Consolidation

Consolidation Trends

In a Health Affairs study, Consolidation of Providers into Health Systems Increased Substantially, 2016-18, Michael Furukawa et al. analyzed provider consolidation trends. The rate of physician affiliation with a health system...
increased by 11 to 51 percent in 2018. Based on the 556 health systems the authors identified, the median number of physicians per system grew by 29 percent. Mergers and acquisitions, creations of new systems, and expansions of previously existing facilities accounted for a net increase of eleven health systems. The study showed that, in only two years, there was substantial horizontal consolidation among health systems as well as vertical consolidation of physicians and hospitals into health systems. The researchers warn that this could complicate regulation efforts and they suggest further research on market concentration's driving factors.

Financial Integration and Impact on Quality

Also published by Health Affairs, Financial Integration's Impact on Care Delivery and Payment Reforms: A Survey of Hospitals and Physician Practices considered whether the potential benefits of healthcare integration outweigh their anticompetitive risks. In a nationally representative survey of 739 sample hospitals and 2,189 physician practices, Elliott S. Fisher et al. found integration between hospitals and physicians generally did not correspond to better quality. The researchers compared complex, simple, and independent
hospital systems based on nine quality indicators and then compared physician practices across different integration systems using nine similar measurements. Though integrated systems supported positive scores for four of nine hospital measures and one of nine practice measures, complex integration systems did not indicate higher quality scores. Researchers observed few systems had installed recommended payment reforms and questioned whether systems lack adequate incentive to move to value-based payment from fee-for-service.

Horizontal Consolidation and Impact on Wages

Following research from RAND Corporation, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages reached unique conclusions about hospital mergers' effects on wages for American workers. The authors, Daniel Arnold and Christopher Whaley, determined in-market hospital mergers increased hospital prices by $521 and reduced wages by $638. This means that when provider concentration within a state increases healthcare costs, workers suffer the brunt of the effects through lower wages and benefits, because employers must pay more for the plans they provide to employees. Cross-market
hospital mergers, however, did not raise prices or impact wages when the mergers crossed state lines.

Vertical Consolidation Concerns Amid COVID-19

Also this month, the National Academy for State Health Policy published State Policies to Address Vertical Consolidation in Health Care by Erin Fuse Brown about the COVID-19 pandemic's effect on vertical healthcare consolidation and its risks to consumers. Although the federal government contributed $175 billion under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the funds primarily benefited large hospital systems while independent providers and physician practices lost significant revenue. This could breed massive, exclusive networks that increase healthcare costs and decrease consumer choice without improving quality. Since COVID-19 compels vertical consolidation that is more likely to evade federal scrutiny, states should pursue policies that minimize associated risks. For example, states may gather comprehensive data, review and approve proposed transactions, oversee consolidated entities for anticompetitive conduct, and control outpatient costs.
Surprise Billing

Last month, the U.S. Department of Health and Human Services (HHS) published the Secretary of Health and Human Services' Report on: Addressing Surprise Medical Billing and acknowledged the significant costs and injustices associated with surprise billing. In particular, the report found that ancillary providers, such as anesthesiologists and assistant surgeons, account for most surprise bills. In addition, when private staffing firms enter a market to staff emergency rooms or provide specialists, out-of-network billing increases by up to 66 percent, which contributes to increased surprise billing. The report recommends Congress enact permanent federal surprise billing legislation to protect patients' abilities to make informed decisions, access transparent pricing, and avoid provider price-gouging. Additionally, the University of Chicago Press published Surprise! Out-of-Network Billing for Emergency Care in the United States, in which Zach Cooper, et al. discuss out-of-network emergency care providers' expensive surprise bills. Emergency care physicians use unchecked bargaining power with
Insurers to raise rates without issue because patients do not choose their emergency care provider. The article explains how New York implemented binding arbitration between insurers and providers and successfully lessened out-of-network billing by 12.8 percent.

Pharmaceuticals

In Medicare Part D Plans Rarely Cover Brand-Name Drugs When Generics Are Available, published by Health Affairs, a team of Vanderbilt and Kaiser Family Foundation researchers studied over 4.1 million Medicare plan-product combinations to assess pharmaceutical cost implications for Medicare and its beneficiaries. Stacie Dusetzina et al. found that Part D plans covered generic-only versions of drugs in 84 percent of cases, so brand-name drugs did not receive preference. In 15 percent of cases, Part D covered both generic and brand-name versions. In these cases, placing both versions of the drugs on the same coverage tier could create higher costs to beneficiaries. The researchers conclude that while states could prevent this by regulation, this may not be worthwhile because it would not likely generate huge savings. Instead, they recommend policymakers monitor...
coverage to ensure Part D consistently covers generics.

The New England Journal of Medicine published the study Patient and Plan Spending after State Specialty-Drug Out-of-Pocket Spending Caps to analyze the cost effects of three states that passed legislative caps at $150 per prescription on out-of-pocket spending for specialty drugs. Kai Yeung, et al. found that for users in the 95th percentile of specialty drug spending, the caps corresponded to an adjusted $351, or 32 percent, decrease in out-of-pocket costs per month per specialty-drug user. The study sampled 27,161 persons under age 65 in commercial health plans from three large nationwide insurers for three years before and three years after the legislation was passed. Notably, while the caps successfully generated savings for persons with serious conditions who spend the most on specialty drugs, the study did not detect increases in overall health plan spending.

If you find additional articles that you would like us to include in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.
Trends in Price and Quality Transparency

- All-Payer Claims Database
- Pharmaceutical Price Transparency
- All-Payer Claims Database

All Payer Claims Databases (APCD)

For more on APCD’s, check out our Legislative Topics: All Payer Claims Databases overview on Medium.

- Pharmaceutical Price
Transparency

Pharmaceutical Price Transparency Legislation

For more on this legislation, refer to our Issue Brief on The Source Blog and the NASHP Center for Rx Pricing.

- Key:
  - Price Transparency Legislation

Recent Action in Price and Quality Transparency

- Recent Legislation
- Recent Litigation
Recent Legislation

Surprise Billing Consumer Protection Act: A BILL to be entitled an Act to amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for certain consumer protections against surprise billing; to provide mechanisms to resolve payment disputes between insurers and out-of-network providers regarding the provision of healthcare services; to require the department to provide for the maintenance of an all-payer health claims database; to provide for in-network cost-sharing amounts in healthcare plan contracts; to establish an arbitration process; to require the Commissioner of Insurance to contract with one or more resolution organizations; to require the promulgation of department rules; to provide for an effective date; to repeal conflicting laws; and for other purposes.

As introduced, enacts the "Modernizing Medication Utilization Act." Beginning January 1, 2021, health plans, pharmacy benefits managers, and pharmacies must make available a patient's specific prescription cost and benefit information in real-time for usage in a healthcare provider's prescribing or electronic health record system at the point of prescribing and at the point of...
Health plans, healthcare providers, pharmacy benefits managers, and pharmacies must partner with intermediaries, such as real-time networks, switches, and translation services, to deliver accurate, patient-specific prescription benefit and coverage, or cash pay, information to prescribing and electronic health record systems; Based on patient-specific benefit and cost information provided in real-time through a prescribing or electronic health record system, healthcare providers must provide information to the patient about the most therapeutically appropriate and lowest cost prescription medication available to the patient at the time of prescribing. This bill requires that prescription cost information displayed in a prescribing or electronic health record system at the point of prescribing include all options available to the patient, including cost options available at the patient's pharmacy of choice; any specialty pharmacy cost, as applicable; and any cash options. This bill provides that health plans and pharmacy benefit managers may not prohibit the displaying of cost, benefit, and coverage information at the point of prescribing or dispensing that reflects other choices, such as cash price, patient assistance, and support programs, and the cost available at the patient's pharmacy of choice.
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Health Care – As introduced, authorizes healthcare facilities to provide an electronic method for insureds or their representatives to acknowledge and sign the statutorily required notice that the insured agrees to receive medical services by an out-of-network provider and will receive a bill for the amount unpaid by the insured's insurer. – Amends TCA Title 33; Title 56; Title 63 and Title 68. (1) Establish an independent dispute resolution process that ensures a fair reimbursement for out-of-network services; (2) Implement a balance bill prohibition for emergency services in an out-of-network facility and for facility-based non-emergency services; and (3) Creates opportunities for transparency and notice to a patient of unexpected medical bills that arise from receiving care from out-of-network providers. Subject to certain exceptions,
this amendment generally applies to health benefit plans, health carriers, out-of-network facility-based physicians, and healthcare facilities. This amendment only applies to entity providing or administering an ERISA self-funded employee welfare plan if the plan voluntarily opts-in.

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As introduced, extends the deadline by which the bureau of TennCare must submit an annual report to the general assembly describing the nature and purpose of any requests to utilize data from the all payer claims database submitted to the bureau or the health information committee from January 15 of each year to January 20. – Amends TCA Title 4; Title 8; Title 56 and Title 71.

As enacted, requires ambulance providers to submit an annual cost and utilization report to the bureau; authorizes the bureau, instead of the comptroller, to assess certain penalties for failure of providers to submit reports; extends the termination date of the ground ambulance provider assessment from “June 30, 2020,” to “June 30, 2021.” – Amends TCA Title 71, Chapter 5, Part 15.

- Recent Litigation
Law, passed in June 2015 (HB 52) by the Ohio Legislature, has been challenged by health care providers arguing that the law's requirements are too broad and would delay patient care. The law requires providers to supply patients with a “good faith” estimate of how much non-emergency, elective health care services would cost individuals after accounting for health insurance. The price transparency law was scheduled to take effect in January 2017 but has been suspended from enforcement pending the legal challenge.

The Williams County Court of Common Pleas issued a temporary injunction against the law. In February 2020, the 6th Circuit affirmed the lower court’s summary judgment ruling and issued a permanent injunction, ruling that the law violated the Ohio Constitution’s one-subject rule which requires that no bill may contain more than one subject, which must be clearly stated in its title. Here, the original bill was intended to regulate and fund the Bureau of Worker’s Compensation, and the transparency provision was an “unnatural,” unrelated addition to the bill intended to cover another subject. Additionally, the court held the transparency provision also violated the Ohio Constitution’s three-reading rule, which requires every bill to...
be considered by each house on three
different days. The court said the entire
legislative history of that bill had been
about workers compensation, and when it
passed both the House and Senate, it
contained no reference to health care
price transparency. Then on June 25,
2015, with no hearings or prior
introduction, the amendment was added
with the price transparency act.
Attorney General David Yost's office filed
The 2019 Oklahoma law,
Patient's Right
to Pharmacy Choice Act
targets PBM
conflict of interest by prohibiting higher
reimbursement rates for PBM-owned
pharmacies and bans PBMs from
preventing pharmacies to disclose cost
information to consumers. PCMA
filed
suit
in Oklahoma district court just before
the new law takes effect on November 1,
2019, arguing that the law "operates
primarily to weaken competition among
pharmacies by limiting the ability of
PBMs to offer their cost-saving and
quality assurance initiatives within the
State of Oklahoma." The parties agreed
to a stay in the lawsuit as the Supreme
Court had granted review of the lawsuit
challenging a similar Arkansas law,
PCMA v. Rutledge.
In September 2017, just three months
after Nevada passed its insulin transparency law (SB 539) in June 2017 to increase transparency over the price of diabetes drugs, two drug lobbying groups, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO), filed a lawsuit asking the U.S. District Court to declare that federal law preempts several provisions of the transparency law. SB 359 requires drug manufacturers to report a range of pricing information for a list of essential diabetes drugs compiled by the state, including pricing history and costs, price hikes above inflation, and rebates paid to pharmacy benefit managers (PBMs). Plaintiffs sued the state claiming the law is unconstitutional and deprives drug makers of their right to protect trade secrets under the Fifth Amendment. The case was voluntarily dismissed after Nevada’s Department of Health and Human Services adopted a trade secret option that would allow pharmaceutical companies to keep certain drug pricing data confidential when they begin complying with the new transparency law, provided they explain why the information shouldn’t be disclosed to the public. Documents related to the case can be found here.
required disclosure of generic drug pricing and sets a floor on prices that PBMs can pay to pharmacies for generic drugs. Pharmaceutical Care Management Association (PCMA), a trade association representing PBMs, brought the suit against the state in 2015.

Closely following the 8th Circuit decision in PCMA v. Gerhart handed down just two months earlier which struck down a similar Iowa law, the District Court of Arkansas was compelled to strike down the Arkansas law in March 2017. The district court found that ERISA preempted the law but Medicare Part D did not.

The 8th Circuit affirmed on appeal and held that both ERISA and Medicare Part D preempted Arkansas' drug pricing law Act 900. Arkansas filed a petition for certiorari, requesting the Supreme Court to review the case, citing split circuit court decisions in the matter of ERISA preemption of PBM laws among the 1st Circuit, 8th Circuit, and D.C. Circuit, which created "'confusion and uncertainty' about state power to regulate drug prices." Multiple states including California and New York signed on the amicus brief to the Supreme Court, urging review of the case.
In January 2020, the Supreme Court granted certiorari of the case. Oral arguments originally set for April 2020 has been postponed due to the coronavirus outbreak.

PhRMA is challenging California's drug price transparency law SB 17 alleging that the law is unconstitutional because it violates the Commerce Clause, the First Amendment, and the Due Process Clause. SB 17, which Gov. Jerry Brown signed 10/9/17, requires pharmaceutical companies to notify insurers and government health plans 60 days in advance of a price increase above a certain threshold and provide a rationale for it. After California federal court's dismissed the original suit (PhRMA v. Brown) on procedural grounds, on September 28, 2018, PhRMA amended and refiled its complaint as PhRMA v. David. Read more on The Source Blog.

In a significant victory for the pharmaceutical industry, the 4th U.S. Circuit Court of Appeals found Maryland's landmark 2017 law (HB 631), which punishes generic drug manufacturers for price gouging, unconstitutional because it violates the dormant commerce clause. The April 2018 ruling reversed the lower court's
decision in a lawsuit originally brought by the generic pharmaceutical industry led by the Association for Accessible Medicines (AAM).

In February 2019, the Supreme Court denied certiorari to review the 4th Circuit decision, effectively putting the nail on the coffin on the law. Read more on The Source Blog.

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