Happy New Year! In this inaugural issue of 2022, we roundup articles and reports that you may have missed from the year end that examine various healthcare price and competition issues, including 1) an observational study on states’ merger review powers and their effect and 2) a review of policy options for addressing the extent and impact of consolidation in California. In addition, we cover articles that examine 3) the correlation between prices disclosed under the new hospital price regulation with total costs of care among commercially insured individuals, 4) an enhanced approach to achieve price transparency, 5) disparities among Medicare and commercial negotiated prices for shoppable radiology services, and 6) findings of a survey on consumer
A team of researchers from The Source on Healthcare Price and Competition and UC Berkeley's Petris Center co-authored a new *Health Affairs* study that found States' Merger Review Authority is Associated With States Challenging Hospital Mergers, But Prices Continue to Increase. Researchers reviewed a 10-year time period in which 862 hospital mergers were proposed and just 42, or 5%, were challenged by states. Among them, 25 of the challenges were headed by eight states where merger review authority was more robust. Even after the challenges, hospital prices in these states continued to rise at similar rates as other states, potentially because most challenges allowed mergers to proceed with conditions that did not adequately address competitive concerns. The authors conclude that although these findings do not reveal an optimal state framework, examining these eight states further could provide valuable insights into how to improve merger review in the states.

In California, hospital, specialist
Physician, and insurer markets are heavily concentrated, leading to higher healthcare prices across the state. A new California Health Care Foundation issue brief, written by The Source's Katherine L. Gudiksen, Amy Y. Gu, and Jaime S. King, highlights that consolidation is not limited to any one health system, market segment, or geographic region in the state. The brief, *Markets or Monopolies? Considerations for the Addressing Health Care Consolidation in California*, indicates that hospital markets, in particular, are now approaching "monopoly levels" in many California counties. In addition, there is mounting evidence that mergers of health care companies are resulting in increased prices for health care services, with "little to no improvement in quality," while also reducing wages for health workers. Given that states play a large role in regulating healthcare markets, California policymakers and state officials could consider additional scrutiny and intervention to mitigate the harmful impacts of high concentration. Specifically, the brief suggests requiring all health care transactions to obtain consent from the state attorney general prior to any transfer of a material amount of assets and expanding the authority of state regulatory agencies to include "affordability standards" when they...
review health insurance plans for sale in California.

Price Transparency
A new federal hospital price transparency rule administered by the Centers for Medicare & Medicaid Services (CMS) requires hospitals to publicly share negotiated prices for at least 300 services to encourage consumers to shop around when choosing healthcare facilities and practitioners, with the goal of lowering healthcare spending. A study published in JAMA Network Open, however, found low compliance with the new rule. In Concordance of Disclosed Hospital Prices With Total Reimbursements for Hospital-Based Care Among Commercially Insured Patients in the US, Michal Horný, Paul R. Shafer, and Stacie B. Dusetzina, write that the new CMS rule provides only a partial picture of the cost of care, limiting its value to patients trying to comparison shop. In a cross-sectional study of over 4.5 million hospital-based encounters for shoppable care in 2018, health care entities that billed for their services independently from the hospital were frequently involved in care delivery, and their reimbursements comprised substantial portions of the total costs of care. The disclosed hospital prices were
weakly correlated with the reimbursements of independent health care entities. These findings suggest that prices disclosed under the new regulation may have limited value to patients attempting to make cost-conscious health care choices.

As Horný and coauthors point out, the inherent fragmentation of the health care system and design short-falls in the new CMS regulation suggest patients may receive incomplete information regarding the cost of shoppable health services. Also writing for JAMA Network, Ezekiel J. Emanuel and Amaya Diana contend that even if patients had a more complete cost picture, that would not lead to greater use of lower-cost, higher-quality services.

In Considering the Future of Price Transparency – Information Alone Is Not Sufficient, the authors argue that transparency alone would not create worthwhile change; instead, reform initiatives must focus on three components for successful health care transformation: information, infrastructure, and incentives. The article provides several policy recommendations tailored to fit this three-pronged approach, including: complementing price information with rigorous quality data, reference pricing, inclusive shared savings, and bundled payment models.
essence, to improve the efficiency and quality of the health care system, publicly available price information must be integrated into the current infrastructure of the delivery system and paired with meaningful patient incentives to shift behavior and reduce costs.

Healthcare Costs

Recent analyses have discovered that many hospitals fail to comply with the price disclosure rule mandated by CMS. Radiology services look to be no exception. New study data from the Radiological Society of North America suggests that roughly two-thirds of U.S. hospitals have not published commercial negotiated prices for at least one of the 13 radiology services designated as a common shoppable service by CMS. In the report Commercial Negotiated Prices for CMS-specified Shoppable Radiology Services in U.S. Hospitals, researchers John (Xuefeng) Jiang, Martin A. Makary, and Ge Bai reported their findings from their analysis of those that did report a price for one of the services (a mean of 2,053 out of 5,700 hospitals, or 36%, as of September 2021). The study found that for hospitals that did share their radiology service commercial negotiated prices were dispersed throughout the
country, often setting price tags that varied by hundreds or thousands of dollars for certain imaging services. The report notes that the median negotiated prices for commercial versus Medicare rates differed substantially for the exact same exam. CT scans of the brain or head, for example, had the highest median negotiated price range for Medicare, ranging from $137 to $813, while mammography had the lowest variance. On the commercial side, contrast-enhanced CT scans of the abdomen and pelvis had the greatest price range. While implementation of the transparency rule alone may not be sufficient to reduce healthcare costs, the study's findings on hospital pricing for shoppable radiology services suggest that greater transparency may help shed light on price differences to benefit payers.

Telehealth
Nearly two years into the COVID-19 pandemic, more consumers have used telehealth than ever before. In a new report from Rock Health, Jasmine DeSilva, Gabrielle Dell'Aquilo, and Megan Zweig conducted a digital health consumer adoption survey that asked 7,980 U.S. adults about their relationship with digital health. Their report,
Consumer Adoption of Telemedicine in 2021, revealed that in 2020, 53% of respondents indicated higher satisfaction with live video telemedicine compared to in-person interactions. However, in 2021, their satisfaction levels dropped to 43%. The authors claim one possible explanation for the drop in satisfaction is that people began to view telemedicine as an alternative to in-person care, rather than a necessary replacement for emergencies. The data suggests that as telemedicine becomes more nuanced, people will move away from monolithic views about the format and hold more complex views, highlighting the opportunity for innovators to compete on experience and outcomes.

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. Stay safe and healthy!

Trends in Price and Quality
Transparency

- All-Payer Claims Database
- Surprise Billing Protections
- All-Payer Claims Database

All Payer Claims Databases (APCD)

For more on APCD’s, check out the report “The Secret of Health Care Prices: Why Transparency Is in the Public Interest”.

- Surprise Billing Protections

State Surprise Billing
Protections

For more on state surprise billing statutes, refer to our Issue Brief on The Source Blog.

Recent Action in Price and Quality Transparency

- Recent Legislation
- Recent Litigation
- Recent Legislation
to, and collect data from patient assistance programs and consumer help centers to better enable healthcare consumers to access quality and affordable healthcare and health insurance. Through public education campaigns and hearings, the office would have a direct line of communication with residents most in need of help. Housed in the Attorney General’s office, it would also have the power to litigate, ensuring that justice is restored for those who have faced adverse health care and health insurance decisions.

An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, in casualty insurance, providing for pharmaceutical cost transparency.

An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, in quality healthcare accountability and protection, further providing for definitions and for responsibilities of managed care plans, providing for preauthorization review standards and for preauthorization costs, further providing for continuity of care, providing for step therapy, further providing for required disclosure and for operational standards and providing for initial review of preauthorization requests and adverse
An Act amending the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, in quality health care accountability and protection, further providing for definitions, for responsibilities of managed care plans, providing for preauthorization standards and for preauthorization costs, further providing for continuity of care, providing for step therapy, further providing for required disclosure, for operational standards and providing for preauthorization and adverse determinations, for appeals, for access requirements in service areas, for uniform preauthorization form, for preauthorization exemptions and for data collection and reporting; and making an editorial change.

AN ACT relating to prescription drugs; revising the information that is reported under the program for tracking and reporting of information concerning the pricing of prescription drugs; requiring wholesalers to make a report; requiring certain reporting entities to affirm the accuracy of the information in the reports; revising requirements concerning the report of the Department...
- Recent Litigation
The lawsuit follows HCA’s 2019 acquisition of Mission Health in North Carolina, which was approved with conditions by the North Carolina AG, although none of which were competitive impact conditions. Plaintiffs, who are North Carolina patients, claim that Tennessee-based HCA used market power garnered from the cross-market merger to demand anticompetitive terms in contracts with insurers, including tying, all-or-nothing, anti-steering, and gag clauses, driving up prices and insurance premiums. Plaintiffs point out in the complaint that even prior to the merger, Mission Health was shielded by a state-administered certificate of public advantage (COPA) and used similar anticompetitive tactics. The COPA ended in 2016 and the further consolidation with HCA has culminated in making Mission Health the most expensive hospital system in North Carolina for many procedures. Plaintiffs seek damages and an injunction to prevent future anticompetitive activity.

Ohio's Healthcare Price Transparency 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 an appeal March 14, 2020. 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.

Act 900 (SB 688), enacted in 2015, 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. The Supreme Court granted certiorari of the case in January 2020. On December 10, 2020, the Supreme Court issued a unanimous decision (8-0, Justice Barrett did not participate in the
case) that overturned the 8th Circuit and upheld the law. The ruling found that Arkansas' law is a price regulation that is not preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Read more in the Source blog.

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.
If you would like to report a possible data discrepancy, please email info@sourceonhealthcare.org or contact The Source here.