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.
Recent Action in Healthcare System Reform

- Recent Legislation
- Recent Litigation
- Recent Legislation
site” as the location where a patient is located for telehealth services and that originates telehealth service to another qualified site, such as the office of a healthcare services provider, a hospital, a rural health clinic, or any other location deemed acceptable by the health insurance entity.

Expands existing coverage parity/reimbursement parity requirements. Requires a health insurance entity to reimburse a facility hosting a patient for a telehealth encounter an originating site fee in accordance with applicable rules and amounts established by the Centers for Medicare and Medicaid Services (CMS).

Adds a private location the patient deems appropriate to receive their healthcare services that is equipped to engage in telecommunication as a location a patient may receive provider-based telemedicine services and requires an in-person encounter between the healthcare service provider, the provider's practice group, or the healthcare system and the patient within 24 months prior to a telehealth encounter prior to the provider-based telemedicine service. Requires a health insurance entity to consider any remote patient monitoring (RPM) service a covered service if the same service is covered by Medicare.
As introduced, makes various changes to the law concerning the electronic delivery of health care and its coverage under insurance policies. This bill adds that telehealth is subject to utilization review in the same manner as an in-person encounter under the Health Care Service Utilization Review Act. This bill requires a health insurance entity to reimburse a facility hosting a patient as part of a telehealth encounter an originating site fee in accordance with applicable rules and amounts established by the Centers for Medicare and Medicaid Services. This bill defines “originating site” as the location where a patient is located for telehealth services and that originates telehealth service to another qualified site, such as the office of a healthcare services provider, a hospital, a rural health clinic, or any other location deemed acceptable by the health insurance entity.

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Insurance Amendments. This bill amends and enacts provisions under the Insurance Code and related to certain health benefit plans and the Health Reform Task Force.

An act relating to health care reform implementation. This bill proposes to create additional reporting, certification, and budget requirements for accountable care organizations; direct hospitals to report certain rate increases to the Green Mountain Care Board; and impose new requirements on contracting between health plans and health care providers. It would require the Green Mountain Care Board to review annually the budgets of designated and specialized service agencies and preferred provider
organizations. The bill would specify that the Green Mountain Care Board's membership must include a health care professional, require the Board to begin exercising its rate-setting authority and to establish site-neutral reimbursement amounts, and direct the Board to review and approve contracts between health plans and health care providers. The bill would also impose limits on health insurance rate increases attributable to administrative expenses and require the Agency of Human Services to report on two-year accountable care organization budget and reporting cycles and on the likely effects of attributing or not attributing State employees and public school employees to an accountable care organization.

An act relating to miscellaneous health care provisions. This bill proposes to address several health care-related topics, including mental health, hospital budget review, expansion of VPharm coverage for certain beneficiaries, and the review and modification of prior authorization requirements.

Health insurance; essential health benefits; preventive services. Requires a health carrier offering or providing a health benefit plan, including (i) catastrophic health insurance policies and policies that pay on a cost-incurred
basis; (ii) association health plans; and (iii) plans provided by a multiple-employer welfare arrangement, to provide, as an essential health benefit, coverage that includes preventive care. The bill defines essential health benefits as those general categories and those items and services within such categories that are covered in accordance with regulations issued pursuant to the Patient Protection and Affordable Care Act in effect as of January 1, 2019. Health benefit plans; special exception. Eliminates provisions of the Code of Virginia authorizing health carriers to sell, issue, or offer for sale any health benefit plan that would otherwise not be permitted to be sold, issued, or offered for sale due to conflict with the requirements of the federal Patient Protection and Affordable Care Act (PPACA), to the extent that the requirements of the PPACA are amended by any federal law.

• Recent Litigation
the Tax Cuts and Jobs Act of 2017. In NFIB v. Sebelius, the National Federation of Independent Business and 26 state attorneys general challenged Congress’ ability to require Americans to purchase health insurance, as doing so would regulate inaction, as opposed to action, in commerce. Finding justifications grounded in interstate commerce or the Necessary and Proper clause lacking, Chief Justice Roberts rested the constitutionality of the individual mandate on the fact that it functioned as a tax – citizens had to prove that they had qualifying health insurance or pay the shared responsibility payment, which was collected by the I.R.S. when people filed their tax returns. Robert’s opinion did not save the individual mandate from controversy for long, however. Following the 2016 election of Donald Trump, the Republican attack on Obamacare continued with new fervor. After numerous failed attempts to repeal the law directly, Congress modified the ACA as part of its tax reform package, the Tax Cuts and Jobs Act of 2017, in December 2017. The tax bill changed the penalty for failing to have health insurance from $695 for an adult to $0, eliminating the tax. Republicans did so for three reasons. First, the Congressional Budget Office predicted...
that eliminating the penalty would reduce the federal deficits by $338 million between 2018 and 2027, which Republicans needed to successfully pass their planned tax cuts. Second, it allowed them to claim that they had delivered on their campaign promises of repealing at least some portion of the ACA. Third, it would allow them to once again challenge the constitutionality of the individual mandate, as it no longer functioned as a tax, and as a result, challenge the entirety of the ACA.

In February 2018, 20 state attorneys general filed suit in the Northern District of Texas against the Department of Health and Human Services and the Internal Revenue Service (Texas v. U.S.) claiming that under the Supreme Court's ruling in NFIB, the elimination of the tax penalty voids the constitutionality of the individual mandate and the entirety of the Patient Protection and Affordable Care Act ("ACA"). They argue that because the Supreme Court's validation of the ACA's constitutionality in 2012 "rested solely on the flimsy support of Congress' authority to tax," now that the tax penalty is eliminated, the entire law is unconstitutional and invalid. On April 9, 2018, another group of state attorneys general filed a motion to intervene in the case to protect the benefits promised to
their citizens and more than $650 billion in federal money scheduled to come to the states under the ACA to provide health care. U.S. District Judge Reed O'Connor heard oral arguments in a three-hour hearing on September 5, 2018. On December 14, 2018, he issued an opinion that struck down the entire ACA as unconstitutional. The judge ruled in favor of the plaintiffs by determining that the "individual mandate" is no longer a tax and is therefore an unconstitutional exercise of congressional authority. The judge also found that the individual mandate was inseverable from the rest of the ACA, which makes the entire ACA unconstitutional. The intervening states appealed the case to the 5th Circuit Court of Appeals and the U.S. House of Representatives joined the appeal. On December 18, 2020, the three-judge panel of the 5th Circuit ruled two to one that the individual mandate was unconstitutional in the absence of a tax penalty, and remanded the case back to Judge O'Connor in the Texas District Court to determine whether the individual mandate can be severed from the rest of the ACA or the entire law must fall with the individual mandate. Twenty democratic states and the House
immediately appealed the 5th Circuit decision to remand the case on severability (California et al. v. Texas et al.) to the Supreme Court for an expedited review in the 2019-2020 term, but the court declined the motion on January 21, 2020. The States and the House of Representatives also asked the 5th Circuit to review the decision en banc, meaning in front of the entire 5th Circuit, and the fourteen judge court decided along party lines (8-6) to decline the request to review the decision on January 29, 2020.

However, in March 2020, the Supreme Court granted review of the 5th Circuit’s decision for the 2020-2021 term and consolidated the two cases Texas v. United States and California v. Texas. The Supreme Court review would considerably fast-track the case by bypassing the lower court remand. The case is expected to be heard in Fall 2020 (oral arguments) and decided by June 2021.

[1] CBO predicted that the savings would result from the nearly 13 million people that would lose health insurance