The Source Roundup: February 2021 Edition

With the inauguration of a new administration in the White House, discussions ramped up on the future of health care and new legislative and regulatory possibilities. This month's Roundup begins with three articles that look at ways to strengthen the Affordable Care Act (ACA) as well as the potential for more significant health reform through the implementation of a public option. On the price transparency front, we cover a report that looks at the effect of New Jersey's final-offer arbitration system for resolving surprise billing disputes and the new price transparency rules put in place by the outgoing Trump administration. Lastly, we check in on healthcare consolidation in the U.S. and the increasing number of physicians subsumed into health systems.

Affordable Care Act

With the new administration in place, Stacey McMorrow walks through how the Biden administration can reverse changes made by the Trump administration and further strengthen the ACA to ensure greater access and affordability in her article Stabilizing and Strengthening the Affordable Care Act: Opportunities for a New Administration, published in the Journal of Health Politics, Policy and Law. Specifically, she advocates regulatory options to expand access to those who do not currently qualify for Medicaid or Marketplace financial assistance, as well as steps to increase enrollment among those already eligible under the ACA. McMorrow also looks at opportunities to expand access for the insured and overcome access barriers to certain services, such as reproductive healthcare.

System Reform

In another article in the Journal of Health Politics, Policy and Law, Between the Waves: Building Power for a Public Option, Jacob S. Hacker argues that while

instituting President Biden's plan for a public option might be currently out of reach, there are ways to implement more immediate and achievable measures to make a public option more feasible down the road. The author sees three crucial steps to creating this "self-reinforcing path": 1) pursuing immediate improvements in the ACA; 2) building necessary policy foundations for a public option while encouraging states to experiment with public plan models; and 3) sowing and strengthening social and political movements to press for more fundamental reform, such as through the Public Health Jobs Corps.

With the change in administration, more and more attention are shifting to new possibilities for healthcare reform. In their Health Affairs article, Pricing Universal Health Care: How Much Would The Use of Medical Care Rise?, Adam Gaffney and others compare different analysts' approaches to projecting changes in utilization and costs from universal coverage reforms. The authors then compare these analyses to the actual changes in healthcare utilization from past large-scale coverage expansions in other wealthy nations. From these comparisons, Gaffney et al. found that there is often a discrepancy between predicted and observed utilization changes, suggesting that analysts underestimate the role of supply-side constraints of utilization, such as the finite number of physicians and available hospital beds. In their review, they found that universal coverage expansions would increase ambulatory visits by 7 to 10 percent and hospital use by 0 to 3 percent and that some administrative savings could offset the costs of the increases in utilization.

Surprise Billing

In 2018, New Jersey implemented a final-offer arbitration system to resolve payment disputes between insurers and out-of-network providers over surprise bills. Under a final-arbitration system, both the insurer and provider provide final offers for the bill's amount, and the arbitrators must select one and cannot choose another amount. In their Health Affairs report, Arbitration Over Out-of-Network Medical Bills: Evidence from New Jersey Payment Disputes, authors Benjamin L. Chartock and others examine how this arbitration amount compares with other relevant provider prices, such as the price Medicare pays locally for the same services, the

median in-network price, and the eightieth percentile of provider charges across all claims per Healthcare Cost Institute (HCCI) data (which is similar to a list price). Chartock et al. found that arbitrators tend to choose the amount closest to the eightieth percentile of provider charges, signifying that New Jersey arbitrators place some weight on this metric in making their decision. This number is fairly high and very generous to providers, pushing the median decision to be 5.7 times the prevailing network rate for the same services. The authors note that there are downsides to this system as the arbitrated prices seem largely untethered to market forces. They suggest that an optimal arbitration system might equip arbitrators with information on commercial in-network prices and Medicare payment rates for the services under billing dispute.

Price Transparency

In their brief for the Kaiser Family Foundation, Price Transparency and Variation in U.S. Health Services, Nisha Kurani, Karen Pollitz, Krutika Amin, and Cynthia Cox outline the two significant price transparency rules put in place by the Trump administration. The first rule requires hospitals to make payer-negotiated rates for common services available to consumers online and to provide rates for all services in a machine-readable file. The second rule requires insurers in individual and group markets and self-funded employer plans to make rates and individualized cost-sharing estimates for certain common services available to enrollees. While the authors are skeptical that the increased transparency requirements will lead to decreased prices or consumer savings for various reasons, they believe that this type of transparency can provide crucial data on healthcare costs in the U.S. It can further provide valuable information on specific providers or communities where prices are exceptionally high, helping spur and inform future policy decisions.

Market Consolidation

While health system reform and price transparency initiatives are essential to improving our health system, keeping an eye on healthcare consolidation can

address the underlying causes for high prices. As is well-documented, consolidation (whether it be horizontal, vertical, or cross-market) in the healthcare sector is a major contributor to high healthcare prices. In a recent study published in Health Affairs, Geographic Variation in the Consolidation of Physicians into Health Systems, 2016–18, Laura Kimmey and others found that physicians are increasingly being subsumed into health systems. Specifically, the study found that in over a third of metropolitan statistics areas (MSAs) in the U.S., half of the physicians in the area were part of a health system in 2018. Overall, physician consolidation increased in 92 percent of MSAs, with the most prominent trend seen in the country's Midwest and Northeast regions. Even in the MSAs that did not experience growth in the number of physicians being absorbed into health systems, a third of those MSAs had more than half of their physicians already consolidated with health systems in 2018. The authors suggest that this trend indicates the need for policymakers to take note, considering consolidation has been linked to higher healthcare prices. They offer options to address this consolidation, such as establishing provider cost growth targets, encouraging the creation of multi-payer alliances to obtain price concessions from providers, restricting the use of anticompetitive provisions in contracts between health systems and payers, and having the FTC take a role in addressing anticompetitive vertical integration efforts by health systems.

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!