

The Source Roundup: January 2020 Edition

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Happy New Year! We hope you had an exciting start to the new decade! In this edition of the Source Roundup, we cover articles and reports from December that discuss: (1) increase in US health care spending in 2018, (2) health system affiliation and how it affects patient access, (3) out-of-network provider charges between 2012 and 2017, and (4) how billing in-network could save millions.

U.S. Health Care Spending Increased 4.6 Percent to Reach \$3.6 Trillion in 2018

In the Health Affairs article [National Health Care Spending in 2018: Growth Driven By Accelerations In Medicare and Private Insurance Spending](#), Micah Hartman et al. examine the increase in health care spending in the U.S. in 2018 as compared to the previous two years and the share of the economy devoted to health care spending, and discuss what influenced these two numbers. According to the authors, U.S. health spending in 2018 increased 4.6 percent to reach \$3.6 trillion, which was a faster growth than the rate of 4.2 percent in 2017, but the same rate of growth as 2016. This growth is largely attributed to the increase of the net cost of health insurance. The Consolidated Appropriations Act, a health insurance tax, was imposed on all health care insurance providers as part of the funding for the Affordable Care Act in 2014. On the other hand, the share of the economy devoted to health care spending declined to 17.7 percent in 2018, a decrease of 0.4 percent from 2017, attributed to a growth in private health insurance and Medicare (which were both influenced by the reinstatement of the health insurance tax). Health care expenditures amounted to approximately \$11,172 per person in 2018. Drug prices rose relatively slowly in 2018, which indicates that buyers are being smarter and perceptive while researching for generic alternatives and other ways to avoid high-priced medicines. The increase in spending is said to be fueled primarily by a tax on

private and federal insurance providers as the IRS's estimate of the tax in 2018 was \$14.3 billion. These numbers show that health care insurers are pushing a lot of the financial burden onto financially-struggling consumers, which are in turn contributing to a health care affordability crisis.

Health System Affiliation for Rural Hospitals May Be Detrimental to Patient Access

In [Access, Quality, And Financial Performance Of Rural Hospitals Following Health System Affiliation](#), published by Health Affairs, Claire O'Hanlon et al. look at the effects of health system consolidation on rural hospitals. The study compared rural hospitals that affiliated with a health system between 2008-2017 with a propensity score — “a weighted set of nonaffiliating (sic) rural hospitals on twelve measures of structure, utilization, financial performance, and quality.” According to the authors, affiliated hospitals experienced reductions in services including on-site diagnostic imaging technologies, the availability of primary care services and specialists like obstetrics, and outpatient nonemergency visits. The study also found that these affiliated rural hospitals dealt with a significant increase in operating costs. Therefore, the authors believed that while being affiliated with health systems may be financially beneficial for rural hospitals, such consolidation may hurt patient access to care.

An Analysis of Provider Charges from 2012-2017

In a [study](#) done by the USC-Brookings Schaeffer Initiative for Health Policy, Loren Adler et al. analyze provider charges between the years 2012 and 2017. Provider charges are prices usually set by the medical provider and represent a list price for the services they provide. For most patients, the negotiated price between their insurance plan and medical provider is more important than the list price because that determines cost-sharing between the insurance provider and the patient. When a patient goes to an out-of-network provider, willingly or unwillingly, they are susceptible to large unsuspected, or surprise billing. The charges, usually from

emergency and ancillary clinicians, are unilaterally set by the medical providers and are subject to minimal market constraint. The authors analyzed data on charges for providers treating Medicare patients between 2012 and 2017 and found that emergency and ancillary physicians, specialties that possess the ability to surprise bill patients, generally charged significantly higher amounts relative to Medicare rates than other specialties. Emergency medicine and anesthesiology specialties have had roughly forty percent growth in the five-year period as compared to other specialties (relative to Medicare costs). Furthermore, the ratio of mean charges to Medicare payment rates for these specialties varied significantly; rates ranged from four times Medicare rates to eleven times Medicare rates. The analysis showed that provider charges have increased throughout the five-year period relative to Medicare costs, but the steepest rises in costs come from emergency and ancillary medicine specialties.

Billing In-Network Could Save \$40 Billion Annually

Similar to the USC-Brookings Schaeffer study, the Health Affairs article [Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians](#) also discusses out-of-network provider billing. Zack Cooper et al. examine the resulting financial risks and lack of a functional health care market from out-of-network charges. The study found that even at in-network hospitals, 11.3 percent of cases involving an assistant surgeon, 11.8 percent of anesthesiology care, 5.6 percent of claims for radiologists, and 12.3 percent of care involving a pathologist were billed out of network. The authors predicted that if the above specialists billed in-network, it would lower physician payments for privately insured patients by 13.4 percent and reduce health care spending for patients with employer-sponsored insurance by 3.4 percent. The total savings would equal approximately \$40 billion annually. Out-of-network billing is prevalent at hospitals in concentrated and for-profit hospitals. Cooper et al. believe that patients need to be protected from financial harm and any policies that come out of this issue should introduce a competitive price for physician services or require providers to be transparent about how much a patient must pay if they are treated by an out-of-network physician.

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. Happy reading!