

The Source Roundup: January 2023 Edition

Happy New Year, Source Readers! We kick off 2023 with highlights of some reports and articles that you may have missed from December. In surprise billing protection efforts, the implementation of the No Surprises Act is hitting unexpected backlogs in the IDR process, while the loophole of ground ambulance surprise bills also warrants further policy attention. Reports on healthcare spending and out-of-pocket costs suggest that healthcare is becoming less affordable as out-of-pocket costs continued to rise. Lastly, a pair of studies on value-based payment models reveal flaws in the systems that warrant improvement.

Surprise Billing

The federal No Surprises Act took effect in January 2022 to protect consumers from surprise billing, including the implementation of an arbitration system that helps determine who ultimately pays for the surprise bills between providers and insurers. The Centers for Medicare & Medicaid Services (CMS) recently released the [Initial Report on the Independent Dispute Resolution \(IDR\) Process April 15 – September 30, 2022](#). According to the report, insurers and providers are overwhelming the arbitration system set up by the No Surprises Act to resolve surprise billing disputes, which was launched in April 2022 after legal disputes delayed the launch. Prior to implementation, it was projected that there would be 17,333 annual claims submitted to the independent dispute resolution (IDR) process. However, CMS reported more than 90,000 claims in less than six months, and there is a significant backlog in

determining which of those claims are eligible for review due to longer than anticipated review and processing. Significantly, the report indicates that 70% of the cases that were reviewed were deemed ineligible. CMS indicates that the Departments are working to enhance the IDR portal to improve the intake and processing of dispute claims.

Even as the federal No Surprises Act seeks to protect consumers from surprise billing, [Emergency: The high cost of ambulance surprise bills](#), a report released by U.S. PIRG Education Trust, found that half of all ambulance rides result in surprise bills, which add to nearly \$130 million a year. Importantly, while the No Surprises Act protects patients from out-of-network and ambulance bills from air ambulance, ground transports—which are far more common—are not covered by the law. According to the U.S. PIRG Education Fund, this is an important loophole in the No Surprises Act that needs to be addressed, as more than 3 million privately-insured patients use a ground ambulance for emergency. However, because ground ambulance are regulated by states and local municipalities, they are far more complex, and the law established the Advisory Committee on Ground Ambulance and Patient Billing specifically to consider future options to address surprise ground ambulance billing. To that end, the report provides an overview of the ground ambulance business models and what states have done to address ground ambulance surprise bills. It recommends that in order to end ground ambulance surprise billing, the government should collect data to determine reasonable payments for ambulance services and establish a clear benchmark payment standard rate for ambulance services sufficient to support operations.

Healthcare Costs and Spending

At the end of last year, CMS released another report on [annual national health expenditures](#). According to the report, overall health spending grew only 2.7%, compared to 10.3% in 2020, mostly due to the decline of pandemic-related federal funding. On the other hand, out-of-pocket health spending increased by 10.4% in 2021, the highest rate since 1985. Specifically, out-of-pocket spending increased for dental services, medical equipment, and physician and clinical services, as utilization rate picked up after the decline in 2020, contributing to the overall rise in out-of-pocket spending. Writing for *Health Affairs*, Anne B. Martin et al. concluded in the article [National Health Care Spending In 2021: Decline In Federal Spending Outweighs Greater Use Of Health Care](#) that the pandemic impact on health spending is expected to wind down, but there may be uncertainties associated with COVID-19 and the impact of inflation and recent economic trends on the health sector is still unknown.

Another report published in JAMA also indicate that health care is becoming increasingly unaffordable for those with employer-sponsored insurance, particularly women. In [Trends in Reported Health Care Affordability for Men and Women With Employer-Sponsored Health Insurance Coverage in the US, 2000 to 2020](#), Avni Gupta and José A. Pagán analyzed data collected from 238,000 adults aged 19 to 64 with health insurance through their employer or union from the last two decades. According to the study, 6% of women and 3% of men found health care to be unaffordable in 2020, compared to 3% and 2% in 2000, respectively. The authors suggest that the difference may be attributable to the fact that women often have higher healthcare needs and challenges to accessing care. They conclude that employers should redesign their benefit packages to address the gender gap.

Value-Based Payment

In another JAMA report last month, researchers examined [Performance of Physician Groups and Hospitals Participating in Bundled Payments Among Medicare Beneficiaries](#). Previous studies have shown that hospitals that participate in bundled payment initiatives have experienced financial savings. In this study, Joshua M. Liao et al. also examined physician practices performance and found that hospitals again showed cost savings associated with both medical and surgical episodes, but physician group practices participating in the same program had savings with surgical procedures but not for conditions that required medical intervention. The authors conclude that this shows hospitals are proven to be suitable participants for bundled payment models, but policymakers should consider how other participant type perform differently when designing future bundled payment models.

In the JAMA report [Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes](#), Amelia M. Bond et al. examine the effect of another value-based payment model. The Medicare Merit-based Incentive Payment System (MIPS) is the largest value-based payment system that pays physicians who care for Medicare patients based on scores in cost, quality, improvement activities and interoperability. The study examined primary care physicians (PCP) that participated in the program in 2019 and found that physicians caring for patients with more complex medical needs unfairly received low MIPS scores even when they provided high quality care with good outcomes. The authors speculate that this may be due to flaws in the MIPS program where it was only measuring a practice's ability to collect measures and also not adequately adjusting scores for PCPs providing care to patients with complex medical needs. Ultimately, the researchers conclude that the MIPS program may

not accurately capture the quality of care that PCPs provide and are thus ineffective at measuring and incentivizing quality improvement among physicians.

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.