

The Source Roundup: March 2020 Edition

In this edition of the Source Roundup, we highlight articles and reports from February that discuss: (1) the prevalence of out-of-network billing during elective procedures with in-network services, (2) affordable care organizations' potential to limit out-of-network spending, (3) findings from the new Health Care Cost and Utilization Report, (4) private health care spending growth varies by hospital referral regions, (5) U.S. has highest healthcare spending despite worst health outcome, and (6) how states policies encourage provider market competition and lower healthcare spending.

The Prevalence of In-Network Care that Result in Out-of-Network Charges

In the *JAMA* article [Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities](#), Karan R. Chhabra et al. evaluated out-of-network billing occurrences across seven common elective operations performed with in-network surgeons and facilities. The authors found that 20.5% of episodes resulted in an out-of-network bill, with the highest percentages being surgical assistant and anesthesiologist bills. In general, out-of-network bills were fewer with ambulatory procedures that generally involved one surgeon and were more frequent in inpatient procedures that were more complex. However, this study suggests that the problem of out-of-network billing is not restricted to a single specialty or setting. Patients in exchange health insurance plans (narrower physician networks; commonly self-insured) were more likely to have out-of-network bills than those in non-exchange plans (broader physician networks; commonly employer-sponsored insurance). Furthermore, the prevalence of out-of-network bills was higher in parts of the South and Northwest parts of the U.S. and lower in the Midwest. While many states (California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Mississippi, and New York) have implemented legislation aimed at lowering out-of-network surprise billing, this study suggests that these legislative policies are not doing what they were enacted to do. New

legislation propose creating a new process to negotiate disputes over reimbursement using mediation, rather than the arbitration process usually favored by health care providers. Furthermore, researchers suggest that providers have an ethical duty to ensure that all staff involved in a procedure accept the same insurance to avoid surprise billing. In the end, the authors suggest that defeating surprise billing practices will have to be a joint effort between clinicians and policymakers.

Affordable Care Organizations Should Limit Out-of-Network Care to Reduce Costs

In the *Health Affairs* research article [Out-Of-Network Primary Care Is Associated With Higher Per Beneficiary Spending In Medicare ACOs](#), Sunny C. Lin et al. examined the relationship between out-of-network care in Medicare accountable care organizations (ACOs) and per beneficiary expenditure from 2012-2015 and highlights the costs of out-of-network care. The authors found that out-of-network primary care was associated with higher spending in outpatient, skilled nursing facility, and emergency department settings. While ACOs are expected to curb health care spending, their inability to prohibit out-of-network care limits such cost containment effect. As such, the study suggests that the Medicare program must develop an explicit incentive program for recipients to seek more of their primary care within network.

Health Care Cost and Utilization Report Shows Price Increases in Employer Plans

The Health Care Cost Institute (HCCI) examines yearly and 5-year cumulative trends in health care spending for individuals with employer-sponsored insurance and develops the [Health Care Cost and Utilization Report](#) (HCCUR). The latest report analyzes data from 2014 to 2018 and shows that in 2018, the average annual health care expenditure for individuals with employer-sponsored insurance was \$5,892—an all-time high. The highest category of spending was professional services, closely trailed by outpatient visits and procedures, facility payments for inpatient admissions, and lastly, prescription drugs. Spending grew 18.4% from 2014 to 2018,

and three-quarters of the growth is attributed to the increase in service prices. Additionally, prices increased by 2.6% from 2017. While that is the lowest rate of growth over the research period, prices still increased by 15% from 2014 to 2018, and there was a 1.8% increase in the utilization of services, the fastest growth rate observed from 2014. Moreover, an individual spent almost 26% more on prescription drugs from 2014 to 2018, the biggest jump of all health expenses.

Healthcare Spending Growth Varies by HHR for the Privately Insured

Since the Health Care Cost and Utilization Report shows that prices are what primarily drive health care costs, policymakers are encouraged to take a look at the trends and introduce legislation that can control health care spending accordingly. In the *Health Affairs* research article [Variation In Health Spending Growth For The Privately Insured From 2007 To 2014](#), Zack Cooper et al. further breaks down differences between Medicare and Medicaid spending versus private insurer spending. The authors found that between 2007 and 2014, private health spending per enrollee grew 16.9 percent, while growth in Medicare spending per fee-for-service beneficiary decreased 1.2 percent. Furthermore, there was variation in private spending growth rates across hospital referral regions (HRRs), or regional health care markets for tertiary medical care. For HRRs in the 90th percentile, spending grew 3.45 percent per year. For HRRs in the 10th percentile of private spending, growth grew at 0.22 percent per year. Such differences are factors that legislators can put into perspective as they try to curb health care spending in America.

U.S. Spends Twice as Much on Health Care but Has Worst Health Outcome

In the Commonwealth Fund article [U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?](#), Roosa Tikkanen and Melinda Abrams look at U.S health care system spending, outcomes, risk factors and prevention, utilization, and quality, relative to 10 other high income countries. The authors find that the U.S. spends more on health care than any other country but has the lowest

life expectancy and health outcomes. In response, they believe that health care costs should be the first issue that policymakers tackle in the U.S. and suggests implementing budgeting practices and value-based pricing of new medical technology. Second, the authors urge addressing risk factors and better management for chronic conditions, as primary and secondary care for chronic conditions is not optimal in the U.S. as a result of affordability issues. Lastly, the authors recommend incentivizing effective care and de-incentivizing less-effective care as a priority to improve health care in the U.S. Studies show that as much as one-fourth of total health care spending in the US is wasteful or overtreatment, and low-value care account for about one-tenth of wasteful spending. Instead, the authors suggest having conversations around evidence-based care between physicians and their patients to determine which tests and treatments are actually needed to treat the condition at hand.

States Should Collaborate to Capitalize on Successful Legislative and Regulatory Approaches to Minimize Healthcare Costs

As states increasingly take the lead in efforts to contain healthcare costs, the Catalyst for Payment Reform and The Source on Healthcare Price & Competition released a study that looks at state legislation to enhance market competitiveness and control costs. The report, [State Policies on Provider Market Power](#), show that many states maintain competition by using existing antitrust statutes to block provider merger and acquisition activity, or implement policies to push for conditional settlements or consent decrees that limit monopolies in the industry. Furthermore, seven states have created commissions or governing body to oversee healthcare price increases and bolster competition. They use methods such as exposing exorbitant pricing, implementing cost regulation, and overseeing merger activities. Other states have implemented global budgets for hospitals and created healthcare cost benchmarking programs. The report suggests that states should share their successful methods and policies to lower health care costs through legislative and regulatory approaches.

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!