The Source Roundup: March 2022 Edition

This month's Roundup includes articles on healthcare merger review, specifically new policy recommendations that explain 1) why regressing price on the HHI does not inform merger analysis, and 2) how courts can implement health equity concerns in merger review. Next, we examine articles that evaluate potential strategies to reduce healthcare costs, including 3) state initiatives that build on past improvement efforts, and 4) financial incentives to reward patients for choosing lower-priced providers. Finally, we look at 5) trends in outpatient telehealth use since the start of the pandemic, and 6) latest rate of hospital compliance with the federal transparency requirements.

Merger Review

In the antitrust context, it seems natural for many empirical and legal scholars to determine whether prices are positively related to measures of concentration, such as the Herfindahl-Hirschman Index (HHI), comparing across different geographic markets or time periods. Pursuing such a question can and do frequently involve using a simple regression of price on the HHI. However, in "On the Misuse of Regressions of Price on the HHI in Merger Review", Nathan Miller et al., caution against such a move as it invites one fundamental problem: mistaking correlation for causation. The authors explain why regressions of price on the HHI should not be interpreted as establishing causation; that is, they do not inform how a change in concentration from a merger would affect prices. They argue that instead, price and HHI are equilibrium outcomes that are determined by demand, supply, and the factors that drive them. Thus, a regression of price on the HHI does not show the sort of causal effect that would be helpful in predicting the competitive effects of a merger. That being the case, the authors conclude that courts and policymakers should not rely on regressions of price on the HHI for the purposes of antitrust merger review.

The pandemic has spotlighted health disparities that have already existed in the United States and increased attention on the impact that the legacy of structural racism has on health outcomes. To that end, a new *Health Affairs* article considers the question: what role, if any, should health equity play in hospital merger reviews? In "Should Antitrust Enforcement Consider Health Equity When Reviewing Hospital Mergers?", Robert F. Leibenluft explains that antitrust merger law, with its focus on the competitive impact of changes in market structure, is generally ill-suited to consider health equity. These concerns are better addressed through more targeted policies, including payment reform, subsidies, and regulations. There is some room, however, for the FTC or a court to consider health equity concerns when confronted with a hospital merger. The article explains how even where merger-related effects on health equity are not tied to competition, they nevertheless should be considered in close calls when the FTC exercises its discretion regarding which mergers it will challenge. Acknowledging that consideration of such issues would be a departure for courts that have restricted antitrust scrutiny to a transaction's impact on competition, the article proposes a nuanced strategy for the FTC to implement greater attention to the impact of hospital mergers on health equity.

Cost Containment

Healthcare costs and spending have become a top priority for both state and federal legislators amid growing concerns of rising costs among employers and consumers. As rising healthcare costs continue to present a critical challenge for states, a new Commonwealth Fund report sheds light on how state policymakers can build on strategies that are being pioneered and refined in states across the country. In "State Strategies for Slowing Health Care Cost Growth in the Commercial Market", Ann Hwang, Amy M. Lischko, Tom Betlach, and Michael H. Bailit present an overview of 10 potential strategies for states to address health care cost growth in the commercial market. As a whole, the proposed strategies address a range of cost drivers and present options that could be attractive to many states, all having been implemented or considered in different state environments. According to the report, strategies that could have the greatest impact include implementing a cost growth target, adopting population-based payment, capping payment rates, and containing

growth in drug prices. These strategies, along with ongoing research and evaluation, can serve as practical guidance in informing the next wave of policy innovation.

Employers are seeking new ways to engage their workers in healthcare decisions in an effort to lower healthcare costs. Rewards programs, which offer financial incentives to patients who receive care from designated lower-priced providers, have grown in popularity among employer-sponsored insurance plans. Examining a program that pays $25-$500 for receiving care from lower-priced providers, new research by Christopher Whaley et al., in Health Services Research found the effort led to modest reductions in prices. The study, "Paying Patients to Use Lower-Priced Providers", builds on a prior pilot program to understand the potential of rewards programs to encourage consumers towards the selection of lower priced services. Using data on 3.9 million enrollees of the Health Care Services Corporation (HCSC), researchers found that the rewards program produced modest reductions in prices, that participation and impact increased over time, and that the greatest cost reductions were concentrated among the use of MRI services. Further, the program's impact did not appear to be affected by enrollees' use of high-deductible health plans or the magnitude of variation in prices between different markets. Despite the increasing adoption of rewards program among employers, Whaley et al. note that the minimal savings due to the program are driven by low patient engagement. Overall, the researchers suggest that to be successful long-term, future cost reducing innovations need to be both commonly used by patients and lead to behavioral changes.

Telehealth

A new Kaiser Family Foundation analysis has found that "Outpatient telehealth use soared early in the COVID-10 pandemic but has since receded." The survey, by Justin Lo, Matthew Rae, Krutika Amin, and Cynthia Cox, assessed telehealth use from March 2019 through August 2021 using data from Cosmos, an Epic dataset, for more than 41 million outpatient visits (the study is relevant only to the population studied and not weighted to be nationally representative.) According to the collected data, outpatient visits by telehealth have declined since the early months of the

pandemic. While pre-pandemic volumes of outpatient visits have been restored, telehealth visits remain elevated. The study also found that patients in rural and urban areas had similar rates of telehealth use, as did men and women. Younger people had higher retention rates of telehealth since the pandemic peak at higher rates, with potential drivers being the enrollees' comfort with the technology, internet access, and the types of services used. Another finding showed that telehealth use for chronic condition management has decreased over the pandemic but remains elevated compared to pre-pandemic levels. The study concluded by acknowledging the uncertainty around telehealth's ability to reduce overall health spending and improve outcomes, but maintains that there is potential, depending on the circumstance.

Price Transparency

A new report released by Patient Rights Advocate shows that one year after a federal rule requiring hospitals to post their prices online went into effect, a large majority of hospitals continue to hide the cost of care from consumers. The Semi-Annual Hospital Price Transparency Compliance Report revealed that hospitals' compliance with major transparency requirements saw a modest increase from 5.6% to 14.3% since its last review in July — with the country's largest health systems serving as the worst offenders. The report is based on an analysis of 1,000 hospital websites for each measure required by CMS regulations, which went into effect on January 1, 2021. According to the report, only 0.5% of hospitals owned by CommonSpirit Health, Ascension and HCA Healthcare met the federal requirements. For-profit HCA, the largest of the three, was found by the group to fall short across every one of its 188 hospitals. Additionally, only 37.9% of the hospitals posted a sufficient amount of negotiated rates, but over half were not compliant in other criteria of the rule, such as listing rates by each insurer and named plan. Noting that no hospitals have been reported to have been issued a penalty for noncompliance, the report emphasizes need to penalize and enforce against noncompliance, and illustrates why clearer pricing is necessary to achieve a more transparent, competitive healthcare system.

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.