

# The Source Roundup: March 2023 Edition

This month's Roundup focuses on articles and reports examining price transparency efforts at both the state and federal levels as well as new recommendations for policymakers on effective healthcare cost containment strategies. States continue to address the lack of knowledge available to the public with all-payer claims databases. Federally, the implementation of new price transparency rules requiring reporting from health care providers and insurers have been examined for compliance and limitations. In addition to price transparency, to get to the bottom of healthcare affordability concerns, researchers and experts are suggesting a variety of cost containment strategies across different political landscapes to tackle the rising cost of health care.

## Price Transparency

As the rising cost of health care continues to be a national concern, state policymakers have become increasingly concerned with the lack of price transparency and have designed various means to understand the scope of the problem, including all-payer claims databases (APCD). Lynn Blewett, Natalie Schwehr Mac Arthur, and James Campbell consider [The Future of State All-Payer Claims Databases](#) in the *Journal of Health Politics, Policy and Law*. APCDs collect information from public and private health insurers and publish reports on health care costs and trends, serving as a health information database for consumers, researchers, and policy makers. However, APCDs do not provide information on the utilization and cost of health care for the uninsured and underinsured, nor data for the large amount of people insured through federal programs like self-funded ERISA plans, the Veterans Health Administration, the Indian Health Service and Federal Employee Health Benefits Program. The authors conclude that even with these limitations, APCDs provide key data on health care spending and valuable information on the drivers of health care costs.

Federally, new price transparency mandates require insurance providers, including employers who self-insure, and hospitals to provide the prices for 500 services and develop online tools for consumers to compare various plans. Published as part of the *Health Affairs Forefront* series, Health Care Prices in the Commercial Sector, Yang Wang et al., discussed the [Insurer Price Transparency Rule: What Has Been Disclosed?](#), specifically the differing levels of compliance and type of information released to the public. While the rules affect both insurers and hospitals, only a fourth of hospitals have fully complied with the rule. Researchers attribute this to only insurers being at risk of the “substantial noncompliance penalty—\$100 per day per impacted individual” leading to insurers having largely complied with the rule and provided an overwhelming amount of data. However, researchers noted that limited standardized information amongst the various plans and a lack of provider identification are hampering the data’s future usefulness to researchers, policymakers, and even individual consumers. As the rule expands to all covered services in 2024, Wang et. al. advocate for policymakers to create standardized provider identification procedures and other necessary changes to improve the policy’s effectiveness.

The actual number of hospitals that have complied with the federal price transparency rule has been debated amongst scholars. In [The Fourth Semi-Annual Hospital Price Transparency Compliance Report](#) by Patient Right Advocate, they estimate that 25% of hospitals are in compliance with *all requirements* of the Hospital Price Transparency Rule, but only 5.8% of hospitals were in total noncompliance, meaning they did not post any standard charges. The report attributes part of the wide variance in the level of hospital compliance to large hospital systems, such as HCA Healthcare, which is completely noncompliant, and Ascension, with only 4% compliance rate. With the Department of Health and Human Services’ reluctance to seek civil monetary penalties, many of the largest systems could refuse to comply without backlash. In addition to enforcement of the rules on noncompliant hospitals, the report suggests requiring real prices to be reported with clear data file standards and with hospital executives personally attesting to the data’s completeness and accuracy.

Kaiser Family Foundation’s Health System Tracker also reported on the [Ongoing Challenges with Hospital Price Transparency](#) as Justin Lo et al., critically examine

the quality and usefulness of the data that hospitals have provided under the federal law. The report notes multiple challenges in converting the raw data reported into functional data for price transparency and comparison by policymakers and consumers. Part of the problem can be attributed to the lack of standardization amongst the specific service and the price (e.g., per diem vs. entire episode charge, dosage variations), how prices are reported for negotiated rates (e.g., proportion or multiplier of a rate), and identification data about the payer class. While CMS has created suggestions for a more unified reporting system, participation is voluntary. In sum, the researchers argue that compliance measurement should also consider the consistency of reported data because inconsistent data can cause unreliable findings.

From the data that were reported and reliably analyzed, Cody Lendon Mullens, Mitchell Mead, and Stanley Kalata et al. have conducted an [Evaluation of Prices for Surgical Procedures Within and Outside Hospital Networks in the US](#), published in *JAMA Network*. Focusing on the 16 surgical procedures that hospitals are required to release prices for under the Hospital Price Transparency Rule, they noted two principal findings. First, higher negotiated prices for in-network facilities were reported for 15 out of the 16 procedures. Second, there was such a wide variability in prices of facilities within and outside hospital networks that the researchers are still unable to determine statistically different rates amongst the facilities. Researchers are hopeful that increasing compliance with the federal rule will reveal more trends and areas of unwarranted variation.

## **Healthcare Cost Containment Strategies**

While price transparency could be helpful, it is not enough by itself to ensure access, affordability, and equity in health care. In [A Road Map for Action: Recommendation of the Health Affairs Council on Health Care Spending and Value](#), the nonpartisan, multidisciplinary council members provide various suggestions and lay out potential pathways for policymakers and stakeholders to achieve higher-value health care spending and growth. These recommendations center around four priority areas. The first area is administrative streamlining with the ultimate goal of reducing

administrative waste. The second area is price regulation and supports for competition to combat consolidation-induced higher prices. Specifically, the council is focused on the private market's negotiated health care prices and the potential for regulatory and nonregulatory approaches. The third area is spending growth targets that can be used as a foundation for other shared health system goals. Council members were the most divided over this topic as a minority of members were concerned that this policy may be too expensive and limit access to innovative treatments, but there was agreement that careful attention should be paid to the few states that have begun to create spending growth targets. The final area is creating a system using value-based payments. The council believes that a fiscally responsible health care system is possible using value-based payments because of the voluntary nature of the model and the ability to increase engagement, effectiveness, and long-term savings. With state and federal support for reductions and health care spending being a fifth of the nation's economy, the council urges policymakers to immediately begin using the provided roadmap to achieve high-value health care spending and growth.

In addition to different ways to make health care more affordable, there is a persist call from insured people that the current system could be improved on a larger scale. Published in *JAMA Health Forum*, Katherine Baicker, Amitabh Chandra, and Mark Shephard provide [A Different Framework to Achieve Universal Coverage in the US](#) starting with defining the social floor, or basic policy, at which someone becomes entitled to health care. Beyond that, the government will need to determine which services to provide and to which patients. Lastly, almost all universal coverage systems include private market choices, in a variety of different ways (e.g., "opt out" systems vs. "top up" supplemental coverage). The authors argue that an incremental change is inefficient because merely adjusting the system will only exacerbate the existing shortcomings. As such, they suggest that a financially sustainable way to ensure access is an automatic enrollment process for those at the social floor.

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.