The Source Roundup: May 2021 Edition

This month's roundup covers academic articles and reports that examined: 1) early results and challenges of the new federal price transparency rule; 2) how to address increasing market consolidation and competition during the COVID-19 pandemic; 3) rising healthcare costs; and 4) how much patients pay and physicians receive when patients receive out-of-network emergency care.

Price Transparency

In response to policymakers calling for greater price transparency of healthcare services for patients and other payers of healthcare, a federal rule from the Department of Health and Human Services took effect on January 1, 2021, requiring hospitals to disclose their standard charges for approximately 300 services deemed shoppable in a publicly accessible and machine-readable format. Three months later, various studies analyzed hospitals' compliance with the regulation and discussed the challenges it faces.

A report published by the Health Care Cost Institute titled The Insanity of U.S. Health Care Pricing: An Early Look at Hospital Price Transparency Data shedded light on whether hospitals are actually disclosing prices of their services. Kevin Kennedy, et al. observed that about half of sampled hospitals published *any* negotiated rates of their services, and only about a third of hospitals published negotiated rates in a manner that fully complied with the regulation. The authors suggest that the lack of compliance is likely a result of low-penalty fines for noncompliance ($300 per day, or $100,000 per year) that are inconsequential for multi-million or multi-billion dollar hospital systems.

Hospital Price Transparency: March 2021 Update, released by consulting firm Milliman, further reports mixed compliance with the regulation since it went into effect in the beginning of 2021. Austin Barrington et al. note in the report that the

Centers for Medicare and Medicaid Services (CMS) has yet to announce significant enforcement actions against hospitals failing to comply with the regulation and has not put out any information on an auditing process or amendments to reporting requirements or penalties for noncompliance. As a result, this report found approximately two-thirds (68%) of reviewed health systems posted a file on either standard charges, payer-specific negotiated rates, or gross charges, but the posted information was inconsistent with a high degree of diversity on how rates were presented. Experts hope the CMS will take action in the coming months to encourage compliance.

There are also challenges to compliance with the new regulation. In Early Results from Federal Price Transparency Rule Show Difficulty in Estimating the Cost of Care published by Kaiser Family Foundation, Nisha Kurani, et al. report that the price for the same health service in the same hospital can vary significantly. For example, Medicare Advantage and Medicaid managed care plans typically pay lower rates than commercial plans for the same services. More specifically, some of the challenges to the new federal rule to require price disclosure include: (1) ways in which prices are measured across health systems are inconsistent; (2) price estimates differ between the consumer tool and machine-readable file; (3) prices can change in short periods of time, and thus payers may be surprised with bill amounts; (4) price information provided is incomplete; and (5) accessibility can be challenging, such as when some hospitals code their files to not appear in online searches and make payers click through many pages to find information. In response to this wide range of interpretation and compliance, the authors suggest that hospitals use consistent file formats, billing codes, service descriptions, and insurer and market naming formats to make it easier to compare price transparency data across hospitals.

Market Consolidation and Competition

In Healthcare Merger & Acquisition Activity Report: Q1 2021, a report released by the Kaufman Hall, Anu Singh reveals that hospitals and health systems had fewer deals in the first quarter of 2021 compared to 2020, likely a result of the lingering

financial repercussions of the COVID-19 pandemic. The first quarter of 2020 had thirty deals, whereas only twelve deals occurred in the same period in 2021; however, those transactions were much larger in value. Acquirers are realizing new value in diversification across both markets and revenue sources. A key driver of many deals is partnering with health systems with an established market presence or health systems with significant local market knowledge.

The National Academy for State Health Policy (NASHP) published A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts. Led by The Source Senior Health Policy Researcher Katherine L. Gudiksen, along with Erin Fuse Brown and Johanna Butler, the policy brief discusses rampant healthcare consolidation that grants consolidated providers market leverage to use anticompetitive contracting practices and charge supracompetitive prices, particularly to commercial insurance plans. Gudiksen et al. note that while anticompetitive behavior can sometimes be prosecuted, it is not enough to disrupt the uneven bargaining dynamic between health insurers and healthcare providers. In response to insurers lacking proper leverage to negotiate favorable contract terms, the authors developed a model act for states titled "Prohibiting Anticompetitive Contract Terms in Health Care Contracts." The model legislation makes common anticompetitive contract terms–including most-favored-nation, all-or-nothing, anti-steering/anti-tiering, and gag clauses– presumptively unlawful under state consumer protection and antitrust laws.

Healthcare Costs and Affordability

In U.S., An Estimated 46 Million Cannot Afford Needed Care, published by Gallup, Dan Witters reports that nearly one in five Americans is not able to pay for necessary quality health care. Healthcare unaffordability is higher among Black adults (29%) and Hispanic adults (21%) compared to White adults (16%). At least one person in 20% of surveyed households skipped on needed care because of financial reasons in the past twelve months, which roughly covers the first year of the COVID-19 pandemic. While low-income households were disproportionately affected by skipping care, all income groups reported reduction in household

spending to afford care. As a result, the majority of Americans support cost containment and broader access policies, such as imposing caps on out-of-pocket costs and lowering Medicare eligibility to age 60.

A report commissioned by NASHP examines one of those healthcare cost containment policies in Independent Analysis: Estimating the Impact of Reference-Based Hospital Pricing on the Montana State Employee Plan. In the report by consulting firm Optumas, Steve Schramm and Zachary Aters examine Montana's state employee plan administered by the Health Care and Benefits Division (HCBD). The plan implemented referenced-based pricing using Medicare's rates for hospital inpatient, outpatient services, and physician payments in 2016. An analysis of the data demonstrates the transition to reimbursing hospitals using a multiple of Medicare rates output an estimated $47.8 million in inpatient and outpatient savings from state fiscal year 2017 to 2019. The report indicates the plan is an excellent cost-containment option because it saves Montana tax dollars without pushing costs onto employees or reducing coverage, and it is subject to more transparent price increases by relying on Medicare's publicly-available pricing methodology.

Surprise medical bills, or when a patient involuntarily or unexpectedly receives care from an out-of-network provider and is billed for the portion not covered by insurance, is another concern of healthcare affordability for consumers. The *Health Affairs* article Emergency Physicians Recover A Higher Share Of Charges From Out-Of-Network Care Than From In-Network Care studied the amount of payment by patients and reimbursement to physicians when patients received care from out-of-network providers. Adam I. Biener, et al. used data from the Medical Expenditure Panel Survey and observed that physicians collected 65% of the charged amount for likely surprise bills, whereas they collected only 52% of the charged amount for in-network bills. Patients with a surprise out-of-network bill for emergency care paid physicians ten times more on average than the amount that in-network emergency patients paid. This data demonstrates the immense financial burden placed on patients when they receive out-of-network emergency care and the need for greater consumer protection from these surprise bills.

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. Stay safe and healthy!