

The Source Roundup: October 2022 Edition

Fall is upon us, and the time is better than ever to sip on a cup of tea (or coffee) and catch up on some of the latest articles and reports! In this month's Source Roundup, we cover a variety of topics in healthcare price and competition. First, we shine the spotlight on the rise in private equity acquisitions, particularly of physician practices and ambulatory surgical centers, and highlight some of the latest studies that examine the implications of these acquisitions on healthcare cost and spending, utilization, and quality. Second, we discuss the latest health insurance coverage and affordability trends and the Congressional Budget Office's report on policy recommendations to rein in healthcare provider prices. Lastly, we examine the continued price transparency efforts, both in terms of state APCDs and the impact of the No Surprises Act.

Impact of Private Equity Acquisitions

The trend of private equity investment in the healthcare industry has been on the rise and many researchers are curious as to its impact. In a study published by *JAMA Network*, Yashaswini Singh et al. examine [Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization](#). The study specifically looked at 578 physician practices, across multiple specialties, that were acquired by private equity from 2016 to 2020 and compared them with independent practices. First, in terms of spending, the researchers found the private equity-acquired practices experienced a \$71 (20.2%) increase in charges per claim and a \$23 (11%) increase in allowed amount per claim. Second, in terms

of utilization, the PE-acquired practices also saw an increased number of new and unique patients. Singh et al. noted that the reason for higher spending associated with private equity acquisition may vary and be difficult to ascertain, while utilization increases may be due to overutilization of profitable services or just changes in management and practice operations. Overall, the authors assert that it is important to understand the mechanisms through which private equity increases profit in order to properly monitor for potential adverse effects from the acquisitions.

Another study in *Health Affairs* also examined the effect of private equity acquisition. Joseph Dov Bruch, Sameer Nair-Desai, E. John Orav, and Thomas C. Tsai found that [Private Equity Acquisitions Of Ambulatory Surgical Centers Were Not Associated With Quality, Cost, Or Volume Changes](#). The authors studied the probability of unplanned hospital visit, total costs, and total encounters for three years pre-acquisition and compared it with three years post-acquisition in 91 ambulatory surgical centers (ASCs) acquired by private equity vs. 57 ASCs acquired by non-PE entities between 2011 and 2014. They found no statistically significant changes. Nonetheless, the authors indicated that regulators should ensure transparency of data from private equity acquisitions to properly track the long-term effects of private equity on the healthcare industry.

Healthcare Costs and Affordability

In a Commonwealth Fund issue brief, [The State of U.S. Health Insurance in 2022](#), Sara R. Collins, Lauren A. Haynes, Relebohile Masitha highlighted findings from a recent consumer survey on health insurance coverage and affordability. Three years since the onset of the COVID-19 pandemic, the survey found that more

Americans than ever have health insurance and yet healthcare affordability remains significant issue. This is because 43% working-age adults are inadequately insured, and a large number of those insured remained *underinsured*, meaning they could not afford access to health care despite their insurance coverage due to high out-of-pocket or deductible costs relative to their household income. Specifically, of those surveyed, 46% indicated they skipped or delayed care because of the cost, and 42% said they had problems paying medical bills. Of those with medical debt, hospital inpatient and outpatient care were the primary source of the bills. Moreover, the main reason consumers do not buy marketplace or individual market coverage was because of high premium costs. Lastly, the survey indicated that while the public is divided on health care priorities, there is consensus on the need to lower healthcare costs. This survey highlights that insurance coverage alone does not mean affordable health care for consumers. As pandemic-related protections expire, the report recommended policy changes to provide greater insurance coverage for all Americans and improving insurance design to protect consumers from medical debt.

In agreement with general consumer sentiment, the Congressional Budget Office (CBO) published a recent report that recommends a cap on healthcare provider price growth. As indicated in many recent studies, the prices commercial insurers pay for hospitals and physician services are much higher than those paid by public health insurance programs, often times due to provider consolidation and resulting market power. In [Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services](#), the CBO suggested several policy recommendations for Congress to address the high prices. First, the report recommends promoting provider competition by targeting market power of hospitals and physicians, including through antitrust enforcement and prohibition of anticompetitive

contracts. CBO projected that adopting this policy approach would have a small effect on price reduction. Second, CBO recommends promoting price transparency by targeting consumers' sensitivity to commercial insurer prices, including through publicly available prices and a federal all-payer claims database. This policy mechanism would likely result in a very small price reduction. Finally, the policy change that would have the greatest effect, with moderate to large price reductions, is capping the level or growth rate of prices. Specifically, the report recommends three approaches to achieve this: 1) capping the maximum amount the providers could receive from commercial payers; 2) capping the annual growth rate of those prices; 3) taxing services that exceed the capped amounts. CBO projected that this policy approach could reduce prices by more than 5% over 10 years.

Price Transparency Efforts Continue

Price transparency has long been promoted as one of the ways to help rein in healthcare costs. State all-payer claims databases (APCDs) are an important tool in price transparency efforts. In a research article for the *Journal of Health Politics, Policy and Law*, Lynn A. Blewett, Natalie Schwehr, Mac Arthur, and James Campbell discuss [The Future of State All Payer Claims Databases](#). The article provides an overview of state APCDs and illustrates several state use cases on how the data allow state policymakers to better understand their healthcare markets and inform policy, including 1) promote market competition through price transparency, 2) adhere to cost growth benchmarks, 3) identify low-value spending targets for cost containment, and 4) enhance regulatory and antitrust enforcement. While the authors note that there are limitations to the reach of state APCDs, particularly the Supreme Court decision in *Gobeille v. Liberty*

Mut. Ins. Co., and the lack of information on the uninsured and underinsured, they maintain that APCDs play a key role in state policy actions and look ahead to federal support, including new funding from the No Surprises Act for improvements in state APCDs, as well as the possibility of a federal APCD.

Another effort in price transparency took the form of the federal No Surprises Act, which prevents patients from receiving emergency department (ED) out-of-network bills from in-network hospitals. In [How State Surprise Billing Protections Increased ED Visits, 2007-2018: Potential Implications for the No Surprises Act](#), published in the *American Journal of Medical Care*, William Encinosa, Keanan Lane, and Noelle Cornelio examine the potential impact of the No Surprises Act by studying the effect of similar state balance billing laws. Specifically, the study looks at whether limiting out-of-network copayments to in-network copayment level would result in an increase in ED visits and spending. The authors examined 15 states with similar policies instituted between 2007 and 2018 and found that the ban reduced spending per visit by 14%, but at the same time, generated a 3% increase in ED visits, which canceled out the cost savings. These additional ED visits were also found to be 9% less urgent compared to visits before the balance billing law, presumably “because individuals [] no longer have the fear of a possible catastrophic surprise ED bill not covered by their insurer, [so] they may be more inclined to go to the ED in marginal, less severe cases.” As a result, the study projected that the No Surprises Act would result in \$5.1 billion in initial savings, but also 3.5 million more ED visits that cost \$4.2 billion, which mostly evens out the cost savings from the surprise billing ban.

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.