The Source Roundup: September 2020 Edition

This month in health policy research, surprise billing and changes in market structures fuel concerns about competition and consumer choice. In addition, some studies on pharmaceutical costs produced hopeful reports.

Healthcare Market Competition and Consolidation

Consolidation Trends

In a *Health Affairs* study, Consolidation of Providers into Health Systems Increased Substantially, 2016-18, Michael Furukawa et al. analyzed provider consolidation trends. The rate of physician affiliation with a health system increased by 11 to 51 percent in 2018. Based on the 556 health systems the authors identified, the median number of physicians per system grew by 29 percent. Mergers and acquisitions, creations of new systems, and expansions of previously existing facilities accounted for a net increase of eleven health systems. The study showed that, in only two years, there was substantial horizontal consolidation among health systems as well as vertical consolidation of physicians and hospitals into health systems. The researchers warn that this could complicate regulation efforts and they suggest further research on market concentration's driving factors.

Financial Integration and Impact on Quality

Also published by *Health Affairs*, Financial Integration's Impact on Care Delivery and Payment Reforms: A Survey of Hospitals and Physician Practices considered whether the potential benefits of healthcare integration outweigh their anticompetitive risks. In a nationally representative survey of 739 sample hospitals and 2,189 physician practices, Elliott S. Fisher et al. found integration between hospitals and physicians generally did not correspond to better quality. The researchers compared complex, simple, and independent hospital systems based on nine quality indicators and then compared physician practices across different

integration systems using nine similar measurements. Though integrated systems supported positive scores for four of nine hospital measures and one of nine practice measures, complex integration systems did not indicate higher quality scores. Researchers observed few systems had installed recommended payment reforms and questioned whether systems lack adequate incentive to move to value-based payment from fee-for-service.

Horizontal Consolidation and Impact on Wages

Following research from *RAND Corporation*, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages reached unique conclusions about hospital mergers' effects on wages for American workers. The authors, Daniel Arnold and Christopher Whaley, determined in-market hospital mergers increased hospital prices by $521 and reduced wages by $638. This means that when provider concentration within a state increases healthcare costs, workers suffer the brunt of the effects through lower wages and benefits, because employers must pay more for the plans they provide to employees. Cross-market hospital mergers, however, did not raise prices or impact wages when the mergers crossed state lines.

Vertical Consolidation Concerns Amid COVID-19

Also this month, the *National Academy for State Health Policy* published State Policies to Address Vertical Consolidation in Health Care by Erin Fuse Brown about the COVID-19 pandemic's effect on vertical healthcare consolidation and its risks to consumers. Although the federal government contributed $175 billion under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the funds primarily benefited large hospital systems while independent providers and physician practices lost significant revenue. This could breed massive, exclusive networks that increase healthcare costs and decrease consumer choice without improving quality. Since COVID-19 compels vertical consolidation that is more likely to evade federal scrutiny, states should pursue policies that minimize associated risks. For example, states may gather comprehensive data, review and approve proposed transactions, oversee consolidated entities for anticompetitive conduct, and control outpatient costs.

Surprise Billing

Last month, the U.S. Department of Health and Human Services (HHS) published the Secretary of Health and Human Services' Report on: Addressing Surprise Medical Billing and acknowledged the significant costs and injustices associated with surprise billing. In particular, the report found that ancillary providers, such as anesthesiologists and assistant surgeons, account for most surprise bills. In addition, when private staffing firms enter a market to staff emergency rooms or provide specialists, out-of-network billing increases by up to 66 percent, which contributes to increased surprise billing. The report recommends Congress enact permanent federal surprise billing legislation to protect patients' abilities to make informed decisions, access transparent pricing, and avoid provider price-gouging.

Additionally, the *University of Chicago Press* published Surprise! Out-of-Network Billing for Emergency Care in the United States, in which Zach Cooper, et al. discuss out-of-network emergency care providers' expensive surprise bills. Emergency care physicians use unchecked bargaining power with insurers to raise rates without issue because patients do not choose their emergency care provider. The article explains how New York implemented binding arbitration between insurers and providers and successfully lessened out-of-network billing by 12.8 percent.

Pharmaceuticals

In Medicare Part D Plans Rarely Cover Brand-Name Drugs When Generics Are Available, published by *Health Affairs*, a team of Vanderbilt and Kaiser Family Foundation researchers studied over 4.1 million Medicare plan-product combinations to assess pharmaceutical cost implications for Medicare and its beneficiaries. Stacie Dusetzina et al. found that Part D plans covered generic-only versions of drugs in 84 percent of cases, so brand-name drugs did not receive preference. In 15 percent of cases, Part D covered both generic and brand-name versions. In these cases, placing both versions of the drugs on the same coverage tier could create higher costs to beneficiaries, The researchers conclude that while states could prevent this by regulation, this may not be worthwhile because it would not likely generate huge savings. Instead, they recommend policymakers monitor

coverage to ensure Part D consistently covers generics.

The *New England Journal of Medicine* published the study Patient and Plan Spending after State Specialty-Drug Out-of-Pocket Spending Caps to analyze the cost effects of three states that passed legislative caps at $150 per prescription on out-of-pocket spending for specialty drugs. Kai Yeung, et al. found that for users in the 95th percentile of specialty drug spending, the caps corresponded to an adjusted $351, or 32 percent, decrease in out-of-pocket costs per month per specialty-drug user. The study sampled 27,161 persons under age 65 in commercial health plans from three large nationwide insurers for three years before and three years after the legislation was passed. Notably, while the caps successfully generated savings for persons with serious conditions who spend the most on specialty drugs, the study did not detect increases in overall health plan spending.

If you find additional articles that you would like us to include in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.