RESEARCH CONSORTIUM
for Health Care Value Assessment

RESEARCH BRIEF NO. 5 | OCTOBER 2021

Price Growth of Medicare Services After Elimination of Consumer Cost-Sharing

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Background

The Affordable Care Act (ACA) requires that non-grandfathered health plans cover specific evidence-based preventive services without consumer cost sharing. As a result, millions of Americans have received zero-dollar coverage and enhanced access to over 80 preventive services, with strong evidence that it has increased uptake, reduced disparities, improved health, and potentially decreased long-term health care spending growth.

In March 2021, a U.S. District Judge in Texas ruled in favor of plaintiffs' challenge to this ACA requirement of coverage without cost sharing of certain preventive services. This ruling could impact the generosity of coverage and use of preventive services, and if upheld, would deal a significant blow to progress in making health care insurance designs "smarter"—wherein high-value services (e.g. COVID-19 vaccination and testing) are covered with little to no patient cost sharing, and low-value services (e.g. those receiving a D rating from US Preventive Services Task Force) require greater patient expenditures.

Included in this lawsuit is an oft stated, but undocumented criticism that the preventive care coverage mandate leads to higher price increases for services that are exempt from cost-sharing compared to clinical services that require an out-of-pocket contribution, and that it results in increased insurance premiums for all enrollees. To address the concern, this study compared Medicare Part B price changes pre- and post- ACA implementation for selected preventive services that were exempt from cost-sharing and comparable clinical services that required out-of-pocket contributions.

Methodology

Commonly used preventive laboratory tests, imaging examinations, and procedures that were exempt from cost-sharing were selected and matched with comparable non-preventive clinical services that require a consumer contribution (see Table 1).

Medicare Part B data were used to compare trends in price growth for the cost-sharing exempt and non-exempt services from 2009-2013. This study period covers 2 years prior and 3 years following the implementation of the ACA mandate for Medicare (January 1st, 2011). Current Procedural Terminology (CPT) codes were used to identify services and measure changes in prices over the study period for the each of the services in Table 1. Total counts of services, billed charges, allowed amounts, and paid amounts were collected for each of the relevant CPT codes in Medicare Part B summary files to calculate a weighted average price paid per service per year.

Table 1: Clinical Services Analyzed

Services Exempt from Cost Sharing	Services Non-Exempt from Cost Sharing
HIV Screening+	Upper GI Endoscopy*
Colorectal Cancer Screening (Colonoscopy and Sigmoidoscopy)*	ECG/EKG
Abdominal Aortic Aneurysm Screening#	Chest X-ray#
Breast Cancer Screening#	Pulmonary Function Test#
Bone Mass Measurement#	Back X-ray#
Cervical Cancer Screening*	Vitamin D Screening+
Cholesterol Screening+	Thyroid Stimulating Hormone Screening+
Lipoprotein Screening+	Metabolic Panel+
Hepatitis C Screening+	Complete Blood Count+

Labels for services are as follows: (+) laboratory tests and screening; (#) imaging; and (*) procedures

Findings

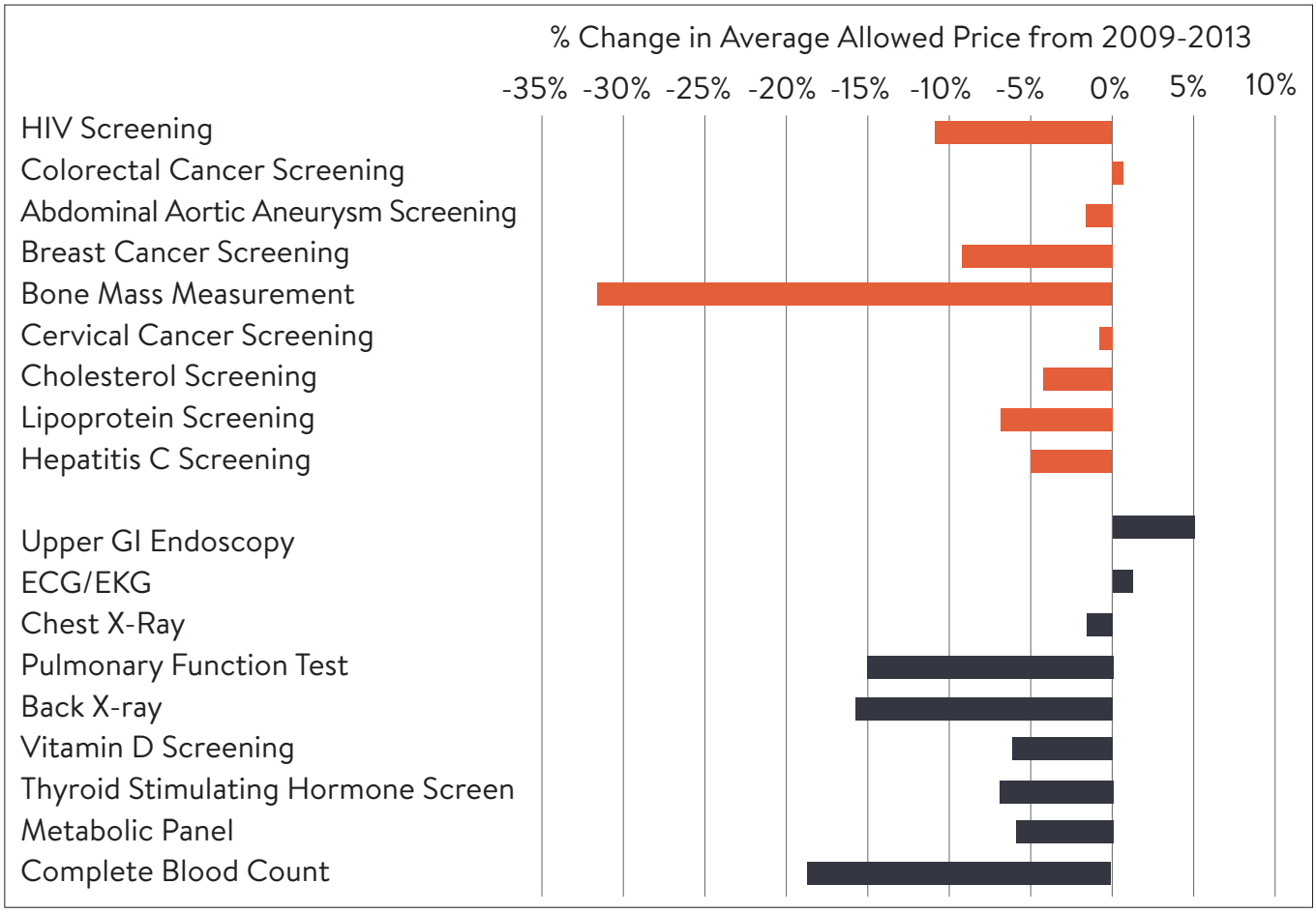
The average Medicare Part B price growth from 2009 to 2013 for the selected services is shown in Figure 1. The average price paid for the cost-sharing exempt services (orange bars) decreased by 7% (range: -32% Bone Mass Measurement; +1% Colorectal Cancer Screening). When looking specifically at the impacts on prices during the year of the enactment of the mandate to eliminate cost-sharing (2011), prices for these select services fell year over year by a slightly lower average amount. Generally, the trends in average prices paid moved consistently over the study period, with small drops in weighted average prices annually for many of the cost-sharing exempt services. These results show little evidence of a dramatic shift in price trends during the first or second year of the ACA policy eliminating cost-sharing (data not shown).

The gray bars in Figure 1 show that the average Medicare Part B price fell by a similar extent (-7.1%), for a comparable set of clinical services that required consumer out-of-pocket contributions (range: -18% Complete Blood Count; +5% Upper GI Endoscopy). There was little change in the 5-year trend for the non-exempt services in the year enactment of the cost-sharing mandate.

Limitations

The findings are limited in that only a select number of cost sharing-exempt and non-exempt services were examined; however, these commonly used services are likely representative of broader trends. Moreover, the generalizability of this analysis is limited by the use of a single payment source (Medicare Part B) that determines prices differently than other payers. Thus, reported Medicare

Figure 1: Average Medicare Part B Price Growth 2009-2013 for Select Cost-Sharing Exempt Services (orange) and Select Services Requiring Consumer Cost Sharing (gray)



pricing variations may be different when compared to other payers. Lastly, the elimination of consumer cost sharing was not the sole health care policy change implemented over the study period and these provisions may have impacted the price and use of selected preventive and non-preventive services.

Discussion

These findings dispel the premise that the elimination of consumer cost-sharing for medical services triggers a rapid and dramatic rise in prices. In light of the current legal challenges to the popular ACA provision, and the implementation of several additional policies by public and private payers that reduce out of pocket costs for essential clinical services, these data provide assurance that increasing prices should not be an anticipated consequence following the elimination of patient cost-sharing—a strategy that has been well-demonstrated to enhance access to care, reduce health care disparities, and improve patient-centered outcomes.

References

1. Han X., Yarbroff K., Guy G., Zheng Z., Jemal A. Has Recommended Preventive Service Use Increased After Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States. Prev Med. 2015;78:85-91 Available from nihms-725575.pdf PubMed

2. Maciosek M., Coffield A., Flottemesch T., Edwards N., Solberg L. Greater Use of Preventive Services in U.S. Health Care Could Save Lives at Little or No Cost. Health Aff. 2010;29(9):1656-60. Available from Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost | Health Affairs PubMed

3. U.S. District Court. Order. Civil Action No. 4:20-cv-00283-0. 2021. Available from kelley-order-on-mo-dism-2-25-21.pdf (wordpress.com)

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The Research Consortium for Health Care Value Assessment is a partnership between Altarum and VBID Health, with funding from the PhRMA Foundation as part of its Value Assessment Initiative, established to promote the pursuit of value in health care delivery in the U.S.

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Support provided by the PhRMA Foundation