Academic Articles and Reports Round-Up: August 2015

The end of summer is always so bittersweet. As the long days filled with sun, swimming, and a bit more time for family and fun wind down, they are replaced with an undeniable excitement in the air. A promise of new opportunities and endless possibilities seems to accompany the start of the new school year. As you gear up for the fall, the August Roundup has all you need to catch up on your reading on healthcare price and competition. The August literature focused on three key topics: 1) Medicare payment reform|2) competition|and 3) state markets.

CMS was busy this summer assessing the results of its existing Medicare Shared Savings Program (MSSP) and proposing new forms of payment reform. On August 26, CMS published *Medicare ACOs Improved Care While Slowing Cost Growth in 2014*, summarizing the results from Year Three of the MSSP. According to the report, the 20 ACOs in the Pioneer Program and the 333 ACOs in the Track 2 ACOs generated over $411 million in total savings in 2014, including all savings and losses in the program. Further, 97 ACOs received shared savings payments of $422 million for achieving their quality and savings goals. The report demonstrates that over the three years the program has existed, both cost savings and quality improvement have consistently improved for both Pioneer and Track 2 ACOs.

In the August 26th issue of the New England Journal of Medicine, Robert Mechanic published his perspective on *Mandatory Medicare Bundled Payment – Is It Ready for Prime Time?,* analyzing the potential benefits of CMS' proposal for a new Comprehensive Care for Joint Replacement Program (CCJR). The program would establish bundled payments for total knee and hip replacement, including all hospital and provider fees, as well as all related Medicare Part A and B payments for 90 days, including skilled nursing facility fees, home care, and hospital readmissions. CMS proposes implementing the mandatory five-year program in 75 metropolitan statistical areas covering approximately 750 hospitals by January 1, 2016. Mechanic argues that CCJR is the "type of bold experiment that's needed to advance payment reform," but because it focuses on high volume, elective, and

highly standardized procedures, the lessons learned may not be entirely generalizable to the issues raised by bundled payments for the rest of Medicare. Still, it's a good place to start.

In August, The Commonwealth Fund examined the success of another Medicare payment reform – Medicare Advantage plans – at using competition to promote cost and quality improvements in its Issue Brief, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*. Authors Brian Biles, Giselle Casillas, and Stuart Guterman, used the most recently available information on Medicare Advantage plans and the Herfindahl-Hirschman Index (HHI) to determine market concentration to examine the levels of competition in the Medicare Advantage markets. The authors report that 97% (2,852 of 2,933) counties surveyed had highly concentrated Medicare Advantage markets, indicating that there is little competition anywhere in the nation. In both rural and urban counties, the average HHI across the nation was well over the 2,500 threshold to qualify as highly concentrated (5,245 rural, 3712 urban). While these findings are not surprising and largely corroborate earlier reports by the AMA and the GAO, they demonstrate the challenge of relying on competition among health insurers to drive down costs. And although further consolidation among health insurers (as we are seeing on a daily basis) may temper some of the provider market power gains and help mitigate ever rising reimbursement rates, it is not clear that these savings will be passed on to consumers in the form of lower premiums. The authors conclude "[t]he benefits of competition can only be relied on in markets where the elements of competition exist," and that does not appear to be in Medicare Advantage.

Competition was also on the minds of Tim Xu, Albert Wu, and Martin Makary, who published *The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price* in the Journal of the American Medical Association. The authors note David Cutler and Fiona Scott Morton's 2013 finding that none of the markets in the 306 hospital referral regions is highly competitive, while more than half are highly concentrated. The authors use evidence to refute two oft-cited benefits of hospital mergers: 1) large hospital conglomerates lead to improved quality control|and 2) consolidation centralizes patients into high-volume centers, which improves outcomes. They present evidence demonstrating the potential harms arising from hospital consolidation, including higher prices and increased utilization.

One particularly interesting argument made by the authors highlights the risks of having a "too big to fail" hospital system in an area, especially one that has never paid taxes, due to its non-profit status.

Speaking of non-profit hospitals and their impact on the community, Erica Valdovinos, Sidney Le, and Renee Hsia published *In California, Not-For-Profit Hospitals Spent More on Charity Care Than For-Profit Hospitals Spent* in the August Issue of Health Affairs. Non-profit hospitals have been getting a lot of heat lately due to complaints that they do not provide sufficient community benefit to warrant the substantial tax breaks they get from their non-profit status. The authors examined whether the levels of charity care and uncompensated care across acute care hospitals differed depending upon a hospital's status. They found that non-profit hospitals provided more charity care (1.9% of profits) than for-profit hospitals (1.4%)|however, there was no statistically significant difference in the amount of uncompensated care provided, which includes the sum of charity care and bad debt. This raises the question of whether non-profit hospitals are labeling some of their care differently. The larger question is whether .5% difference in charity care is sufficient to support a claim for tax exemption.

August also provided some interesting insights into variations among the states in terms of cost containment. Pinar Karaca-Mandic, Brent Fulton, Ann Hollingshead, and Richard Scheffler, published a highly relevant article titled *States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market in 2010-2013*, in August's Health Affairs. The authors found that states with prior approval authority over premium increases experienced overall lower premiums and declining premiums from 2010 to 2013, while states with no rate review authority or just file-and-use authority saw higher premiums and a modest increase in the same time period. These findings suggest that even modest levels of rate review authority can assist in cost control. Also on the state level, D. Polsky and J. Weiner from the Leonard Davis Institute for Health Economics examined the impact of *State Variation in Narrow Networks on ACA Marketplaces,* and provided information on narrow networks across the 50 states and the amount of choice patients have in the state marketplaces. The report is full of interesting charts, graphs, and maps on narrow networks throughout the country and it even provides a fun chart of T-Shirt Size Networks by State.

Well that’s it for August! For those of you still thirsty for more – Health Affairs provides an edited version and video link of Judy Woodruff’s interviews with five former Secretaries of Health and Human Services. Happy watching!