Academic Articles & Reports Round-Up: February 2016

Although February's literature was light in quantity, it was high in quality. The bulk of February's articles and reports focused heavily on marketplace competition, healthcare consolidation, healthcare cost, pharmaceutical price reform initiatives, bundled payments, and high-deductible health plans.

MARKETPLACE COMPETITION

The Commonwealth Fund published an issue brief entitled *Implementing the Affordable Care Act: Promoting Competition in the Individual Marketplace*. In its brief, the Commonwealth Fund explores how the ACA has influenced individual healthcare marketplaces in Kansas, Nevada, Rhode Island, and Washington.[1] To understand the impact the ACA has had in these markets, the Commonwealth Fund interviewed insurers, insurer representatives, senior department of insurance officials, and senior marketplace staff members about their marketplaces models. The Commonwealth Fund found that the marketplaces, in these four states, promoted price competition in many ways, including: comparison shopping, increasing marketplace insurer participation, insurers competing for consumers by lowering silver plan costs, insurers setting aggressive or conservative prices (due to marketplace uncertainty), and extensive state rate review programs. The Commonwealth Fund also acknowledged that insurers are competing, in state marketplaces, via plan costs (versus quality)—but it is hopeful that, as insurers and state marketplaces collect and compile data, consumers will be able to shop healthcare plans based on both cost *and* quality.

HEALTHCARE CONSOLIDATION AND QUALITY

Health Services Research published a capsule study on the very specific topic of *Health System Consolidation and Diabetes Care Performance at Ambulatory Clinics*. In the article, the authors studied whether consolidation of ambulatory clinics, in Minnesota and its surrounding area, resulted in better quality for diabetes patients. After surveying 661 ambulatory clinics, the authors found that acquired clinics began improving performance in the third year, post-acquisition, and that, by their fifth post-acquisition year, they had improved even more. The authors also found that the increase in a system's size, post-acquisition, was only associated with "slight performance improvements." As such, the authors concluded that health system acquisitions improved diabetes care performance, but they do not attribute this improvement to the increased size of the healthcare system.

HEALTHCARE COST

Healthcare Practitioners

The Texas Heart Institute Journal published an article on *Cutting the Cost of Health Care: The Physician's Role*. In this article, the author, a medical doctor, explains the role healthcare practitioners play in healthcare price increases, and offers solutions they can implement to become more aware of their role in and to decrease healthcare costs, generally. The author argues that "the physician's pen" is the "most expensive technology in today's health care." He explains that practitioners often overuse "exorbitant" tests and procedures that require little time and that are reimbursed on a per-procedure (versus a value-based) system. He also argues that practitioners rely, excessively—and oftentimes unnecessarily—on advanced technology out of fear of litigation. And, finally, the author argues that most practitioners are simply unaware of the cost of the treatments they prescribe. Much in line with other literature published on healthcare cost, the author concludes that healthcare practitioners could play a pivotal role in decreasing

healthcare costs and that medical schools should begin training practitioners about cost-consciousness as early in their careers as possible.

Critical Care Pharmacists

On a similar note, Critical Care Medicine published an article entitled *Value-Based Medicine: Dollars and Sense*, wherein the author, a pharmacist, examines the impact pharmaceutical costs have on critical care medical expenditures, the role critical care pharmacists could play in the enhancement of value-based medicine, and why simple, "silo-based" pharmaceutical cost control measures are not the best solution. The author explains how biologics (which are not yet comprehensively regulated), drug shortages in the ICU setting, and generic medicine impact critical care healthcare cost and how pharmacoeconomic studies could be used to augment practitioner decision making. The author concludes by challenging researchers to look beyond the mere cost of a pharmaceutical drug when discussing healthcare costs and to also consider a drug's cost-effectiveness and value.

PHARMACEUTICAL PRICE REFORM

The New England Journal of Medicine published an article on *Pharmaceutical Policy Reform—Balancing Affordability with Incentives for Innovation*. In this article, the authors analyze recent and current pharmaceutical price reform initiatives and explain which would be the most successful. The authors begin by explaining that requiring pharmaceutical companies to directly negotiate prices with the federal government for Medicare Part D insurance would not likely succeed due to "little congressional appetite" for such initiatives. As the authors note, pharmaceutical companies and patient advocacy groups, alike, understand that increasing the government's involvement in pharmaceutical price-setting could easily result in reduced patient access, reduced pharmaceutical investments, and, ultimately, stifled

innovation.

The authors instead propose three alternative methods for reducing prescription drug costs for selected drugs, for selected payers, or for both. First, the authors suggest that lawmakers promote generic competition. Second, they argue that lawmakers could reform the federal 340B Drug Pricing Program (which provides certain hospitals with 20-50% discounts on outpatient drugs) to require the hospitals that receive the discounts to actually pass these savings onto their patients (as of now, no requirement exists and some hospitals keep the profits they make on the discounts). And third, the authors argue that lawmakers could also consider expanding value-based benefits design (via reference pricing) for drugs under Medicare Part B. Such a pricing scheme would allow patients to choose between lower- and higher-value treatments for which there are substitutes—and to pay the difference for the lower-value treatments.

BUNDLED PAYMENTS

Health Policy published an article on *New Pricing Approaches for Bundled Payments: Leveraging Clinical Standards and Regional Variations to Target Avoidable Utilization*. In this article, the authors sought to develop a comprehensive bundled payment model that draws input from clinician-defined best practice standards, as well as regional variations in utilization. The authors designed their study around stroke care and pricing. The authors found wide treatment variations within regional utilization areas and determined that "normative pricing models for stroke episodes result[ed] in increasingly aggressive redistributions of funding." In the end, the authors conclude that novel bundled payment pilots—which take into account clinically-informed pricing—can prove effective.

HIGH-DEDUCTIBLE HEALTH PLANS ("HDHPs") &amp|EMPLOYERS

Health Affairs published an article on *High-Deductible Health Plans* and their potential impact on healthcare access and outcomes. The article comprehensively examines what HDHPs are, the ACA and IRS provisions that govern them, the current issues with them, and how they will likely change in the future. The author explains that HDHPs were created as a mechanism to decrease wasteful health spending|multiple studies show that increasing deductibles does, in fact, decrease healthcare use. The issue, the author highlights, is whether the decreased healthcare use is in the area of necessary (preventive) or unnecessary care. The author concludes by predicting that HDHP coverage and cost will be modified in the next few years as a result of value-based insurance designs (where consumers pay more for "lower-value treatments" and less for "higher-value treatments")|potentially adding "copper" plans to state marketplaces to increase consumer participation in them|and the shifting of high employer plan "Cadillac Taxes" from the employer to the employee.

The New England Journal of Medicine also published an article that explores *How Employers Are Responding to the ACA*. The authors explain that, since the inception of the ACA, employers have to choose whether to "play or pay" for their employee's insurance plans—and that, for many reasons, most employers have chosen to "play." The authors attribute employers' willingness to "play" to a variety of factors, including the fact that there is no cost advantage to discontinuing health coverage and the business community's skepticism that the government can manage large social programs in an efficient manner. The authors also explore future initiatives and legal changes that may affect employers' decisions. These include: the likelihood that the 2020 nondeductible Cadillac Tax provision will become effective and the controversies surrounding HDHPs.

See you next month!

[1] The Commonwealth Fund studied these four states because their silver plans are priced at or below the national monthly premium average of $314|these premiums increased less than 1% between 2014 and 2015|and at least one new insurer entered these marketplaces in 2015.