March Articles & Reports Roundup

It's been a big month in health law! *King v. Burwell* was argued before the Supreme Court, the House voted to repeal the sustainable growth rate (SGR), a two-year CHIP extension was passed, and the Supreme Court held that physicians did not have the right to sue state Medicaid programs for greater reimbursements in *Armstrong v. Exceptional Child Center*. While you were busy reading about these and countless other developments in our ever changing healthcare system, quite a bit has been published related to healthcare prices and competition.

This month's Roundup will highlight new developments and research on consumer-directed/high deductible health plans, price and quality transparency, payment reform efforts, and antitrust enforcement.

Consumer-Directed/High Deductible Health Plans

As more and more healthcare costs are shifted onto individual patients via high deductible health plans and increased cost sharing mechanisms, health services researchers have begun to examine the impact of this shift on the patient population and health care costs in general. The Center for American Progress (CAP) published, The Great American Cost Shift: Why Middle Class Workers Do Not Feel the Slow Down in Health Care Spending. The report reveals that the employee contributions for health care expenses increased at a rate that was more than double the average annual growth of real per-capita health care spending. This increase also outpaced employers' costs of offering health care benefits by more than 40%. The report demonstrates that

almost all players in the healthcare marketplace are realizing savings, except employees. The report's authors, Topher Spiro, Maura Calsyn, and Megan O'Toole, recommend increased transparency around employer and employee apportionment of health benefit costs, sharing savings with employees, and reduction in cost sharing for primary care and preventative care visits.

In the Kaiser Issue Brief, Consumer Assets and Patient Cost Sharing, Gary Claxton, Matthew Rae, and Nirmita Panchal examined this issue further by analyzing data from the Survey of Consumer Finances to determine whether households could afford the cost sharing required in many of the ACA plans. They found that many families up to 400% of the federal poverty level would have trouble meeting the cost sharing obligations imposed by the Affordable Care Act if they were to become seriously ill.

Both the Kaiser Issue Brief and the CAP report acknowledge the fact that increased consumer cost sharing has contributed to the slow down in health care spending, but also note that increased cost sharing can be a significant impediment to patients seeking needed care. Regulators and employers may find striking this delicate balance very difficult, and the cost sharing mechanisms in the ACA may need to be altered in order to do so.

In the NBER Working Paper, Do Consumer Directed Health Plans Bend the Cost Curve Over Time?, Amelia Haviland and colleagues examined whether the increased responsibility placed on consumers will actually lead to cost savings in the long run. The research found that employers that offered high-deductible health plans saw savings of approximately 5% per year for three years. Patients reduced spending on outpatient services and pharmaceutical drugs, with little impact on emergency or inpatient services. However, the overall impact on patient outcomes was not examined.

Price and Quality Transparency

As consumer directed and high deductible plans transition patients into consumers of health care, these patients' ability to make informed decisions regarding health care services becomes of utmost importance. Numerous initiatives have attempted to provide price and quality information to patients and providers in a manner that will enable them to make better health care decisions and improve efficiency.

In Public Reporting of Cost Measures in Health: An Environmental Scan of Current Practices and Assessment of Consumer Centeredness, Bridges et al. found several factors limit consumers' ability to effectively use existing price transparency tools, including a focus on charges, rather than out of pocket costs|heterogeneity in cost measures|a lack of consumer centeredness in the presentation of the information|and failure to enable side-by-side comparisons of both price and quality information. Each of these factors is extremely important to enabling patients to make efficient and effective health care choices. Matthew Austin and colleagues also found national attempts at quality reporting revealed significant variance in hospital ratings in their article, National Hospital Ratings Systems Share Few Common Scores and May Generate Confusion in this month's *Health Affairs*.

The March variety issue of *Health Affairs* broadly questioned How Valuable Is Information?. On the patient side, James Robinson, Timothy Brown, and Christopher Whaley found Referenced-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery. The authors examined the California Public Employees Retirement System (CalPERS) use of reference based pricing to encourage patients to use lower

priced ambulatory surgery centers rather than more expensive outpatient hospital departments. The shift resulted in an 8.6% increase in ambulatory surgical center use and a 19.7% decrease in total employer and employee spending.

While reference pricing may have an effect on consumer behavior, other efforts have had not enjoyed as much success. Saurabh Rahurkar, Joshua Vest, and Nir Menachemi argue Despite the Spread of Health Information Exchange, There Is Little Evidence of Its Impact on Cost, Use, and Quality of Care. After analyzing 27 studies of how health information exchange (HIE) impacts cost, service use, and quality, the researchers concluded that the studies with the strongest research designs were less likely than others to associate benefits with HIE. More research is needed on both transparency and HIE initiatives to determine under what circumstances the implementation costs prove worthwhile.

Payment Reforms

The academic literature in March also considered how payment reform efforts impacted health care usage and expenditures. Mark Friedberg and colleagues from RAND published its latest research report, Effects of Health Care Payment Models on Physician Practice in the United States, which examined the effects that five payment models other than fee for service (capitation, episode-based and bundled payments, shared savings, pay for performance, and retainer-based practice) have on physicians and physician practices. The researchers found that while many physicians experienced significant apprehension about the non-clinical burdens associated with the new payment models and practice leaders had changed the organization of their practice groups to respond to these new payment models, the new models

did not significantly impact physician income or face-to-face patient care.

For an in depth look at a shared savings/payment for performance reform initiative, check out Avalere Health LLC's recent report on Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract. Similar to the payment model for Pioneer ACOs in Medicare, the Alternative Quality Contract holds providers accountable for a global, risk-adjusted budget that provides bonuses for quality. Providers agree to two-sided risk sharing, in which they share in both savings and losses. Avalere conducted a series of interviews with key stakeholders to identify key lessons learned and observations to inform future payment reform innovations. Importantly, the researchers found that payment reform programs can drive significant change in healthcare spending, but they often take substantial time, consistent goals, and commitment from payers to do so. Stakeholders felt that reforms proved most effective when providers had "skin in the game" and sufficient data on spending and quality. The AQC can provide valuable lessons for the Medicare Shared Savings Program as well as other private payment reform models.

Antitrust

Last, but not least, Regina Herzlinger, Barak Richman, and Kevin Schulman published Market-Based Solutions to Antitrust Threats – The Rejection of the Partners Settlement, in the March 4th edition of the *New England Journal of Medicine*. The authors hail the decision to reject the Partners move to acquire three new hospitals (see our blog post describing the deal), as a victory that will avoid price increases as well as open the door to more innovative competitors. The authors express skepticism about the

ability of state attorneys general to manage conduct remedies well enough to avoid the anticompetitive effects associated with many mergers and acquisitions by dominant healthcare entities. Instead, the authors argue that expansion by dominant provider organizations should be restricted in favor of permitting innovative competitors, like telemedicine providers, into the market. We at the Source agree.

That’s it for the March Roundup! Thanks for reading and let us know if you have comments or suggestions for articles or reports to include in April.