

The Source Roundup: February 2019 Edition

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Happy February! As we eagerly await this year's health policy valentines on Twitter, we review recent academic articles that examine a variety of issues related to health care costs, including 1) the effect of vertical integration in health care, 2) health reform and theories of cost control, 3) why the US spends so much on health care, 4) how ACOs use population segmentation to care for high-cost patients, 5) characteristics and spending patterns of high-cost Medicare patients, and 6) an evaluation of bundled payments for joint replacement.

The Effects of Vertical Integration in Health Care

Antitrust enforcement actions challenging horizontal mergers, along with federal policies incentivizing integration, have resulted in a shift towards vertical health sector mergers. The Source's own advisory board member, Tim Greaney, argues in [The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?](#), published in *The Journal of Law, Medicine & Ethics*, that such vertical mergers should be closely scrutinized. Greaney highlights that vertical mergers in health care may harm competition, especially since provider, payer, and pharmaceutical management markets already experience conditions that put them at risk for inhibited competition. These conditions include high concentration, barriers to entry, and regulations that encourage actors in these markets to integrate. Inhibited competition may especially harm consumers. For example, one common type of vertical integration, hospital

acquisitions of physician practices, could prevent rival hospitals or potential market entrants from competing in the market because they do not have sufficient access to physicians. This may result in higher prices. Therefore, antitrust enforcement entities should expand their efforts to include rigorous monitoring of vertical mergers, as well as horizontal mergers.

Health Reform and Theories of Cost Control

Although cost is a central theme in health reform proposals, it is not always clear what cost means. In [Health Reform and Theories of Cost Control](#), published in *The Journal of Law, Medicine & Ethics*, Erin C. Fuse Brown provides a framework for assessing health reform plans on their theories of cost control. Fuse Brown defines costs as the burden consumers bear to obtain health care, including individual and employer's share of health insurance premiums and out-of-pocket costs for cost-sharing or non-covered health care. Her framework depends on a core principle: health care cost control policies must address price and utilization. Applying this framework to the Affordable Care Act (ACA) and the Republicans' 2017 legislation to repeal and replace the ACA, the analysis reveals that the ACA was somewhat successful in controlling health care costs, while the Republican proposal did not include policies targeted to control costs. Specifically, her analysis shows that the ACA's theory of cost control focused on reducing Medicare utilization and payment rates and private market utilization controls. On the other hand, the 2017 legislation to repeal the ACA focused on reducing federal health care spending, reducing regulation, and increasing state flexibility, without addressing prices or utilization. The information yielded by this analysis is important for policymakers and consumers seeking to evaluate

whether particular policies are likely to result in lower health care costs for consumers.

Why the US Spends So Much on Health Care

The 2003 article [*It's the Prices, Stupid: Why the United States is so Different from Other Countries*](#) established the now common mantra that the United States spends much more on health care than other similar countries because prices are higher. The study's authors revisit this topic in a *Health Affairs* article aptly titled [*It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*](#). This time, the authors add an additional area of focus: the growing differential between prices paid in the public and private sectors. Fifteen years later, the authors find that the U.S. still spends much more than other similar Organization for Economic Cooperation and Development (OECD) countries – U.S. spending was 145 percent higher than the OECD median (with the 2016 U.S. per capita health spending being \$9,892, as compared to \$4,033 for the median OECD country). However, unlike in 2003, private insurers in the U.S. paid far more than public sector insurers. A recent Medicare Payment Advisory Commission (MedPAC) report estimates that prices for private insurers are 50 percent higher than Medicare prices. Given this stark differential, the authors recommend that efforts to lower health care prices in the U.S. start with addressing the high prices private insurers and self-insured corporations pay for health care.

How ACOs Use Population Segmentation to Care for High-Cost Patients

Payment and delivery reform models like Accountable Care

Organizations (ACOs) have been developed to control costs while also meeting patients' complex medical, behavioral, and social needs. A small number of ACOs have segmented their population of high-need, high-costs patients into groups of patients with similar needs, though information about such efforts is sparse. A recent Commonwealth Fund article by Ann S. O'Malley et. al., [*How Accountable Care Organization's Use Population Segmentation to Care for High-Need, High-Cost Patients*](#), reviews this approach. The rationale behind segmentation is that it will allow ACOs to more easily match groups of patients with interventions that meet their particular needs. Segmentation is also thought to reduce costs and improve patient outcomes. The analysis finds that ACOs take different approaches to population segmentation and identifies challenges to assessing the effectiveness of segmentation efforts. Notably, the researchers find that cost or quality changes cannot necessarily be attributed to segmentation or more general risk stratification efforts. Still, segmentation efforts may be important for improving program management and some process measures. More robust program evaluations that consider broader health outcomes and include more patient data would be helpful for better understanding the effect of segmentation programs.

Characteristics and Spending Patterns of High-Cost Medicare Patients

[*Characteristics and Spending Patterns of Persistently High-Cost Medicare Patients*](#), published in *Health Affairs*, identifies characteristics of Medicare beneficiaries who account for the top 10 percent of Medicare spending. The analysis, authored by José F. Figueroa et. al., finds that nearly 30 percent of so called "high-cost beneficiaries" remained high-cost over the three-year study. These "persistently high-cost patients"

accounted for nearly 20 percent of total Medicare spending, although they made up only three percent of the Medicare population. Persistently high-cost beneficiaries spent more across all spending categories, but their spending was greatest for outpatient and inpatient treatments and drugs. Notably, persistently high-cost patients spent four times more than non-persistently high-cost patients on drugs and outpatient services. In terms of individual beneficiary characteristics, the study finds that high cost patients tended to be younger, more likely to identify as a member of a racial or ethnic minority group, be eligible for Medicare because of an end-stage renal disease diagnosis, and be dually eligible for Medicare and Medicaid. This data may be used to direct efforts to reduce spending and improve outcomes towards patients who are more likely to remain high cost over time.

An Evaluation of Bundled Payments for Joint Replacement

A recent *New England Journal of Medicine* study finds that the first two years of The Comprehensive Care for Joint Replacement program resulted in moderate savings. The program

is well-known as a bundled payment model intended to lower health care costs across an entire episode of care. In 2016, The Centers for Medicare and Medicaid Services (CMS) randomly assigned hospitals in particular metropolitan areas to participate in the program and therefore be subject to bundled payments for all hip and knee replacements. Participating hospitals that spend less than the hospital-specific benchmark amount are entitled to share in savings, while participating hospitals that exceed the benchmark spending amount are penalized. Michael L. Barnett et. al. compared spending and patient outcomes between hospitals mandated to participate in

the program and control hospitals in [Two-Year Evaluation of Mandatory Bundled Payments for Joint Replacement](#). The authors find that, during the first two years of the program, participating hospitals experienced a modest decrease in spending and no increase in the rates of complications. The reduction in spending was due to a relative decrease in the number of patients discharged to post-acute care facilities. Additionally, although the reduction in spending was offset by bonuses paid to hospitals that spent less than the benchmark, there was still a small net savings.

That's all for this month's Roundup. As always, if you find articles or reports that you think should be included in the monthly Roundup, please [send](#) them our way. Enjoy your reading!