Academic Articles and Reports Roundup: March 2017

Happy April! We hope you are enjoying the start of longer and warmer days. This month's roundup includes articles from March about 1) the impact of reference pricing|2) policies to promote healthcare market competition|3) chargemaster list prices|and 4) ACA enrollment figures.

1) The Impact of Reference Pricing

Reference Pricing Changes the 'Choice Architecture' Of Health Care For Consumers published by James C. Robinson, Timothy T. Brown, and Christopher Whaley (Health Affairs), discusses how reference pricing has impacted provider prices, patient choices, quality of care, and employer expenditures. The authors found that reference pricing – incentivizing patients to choose lower-cost but high-quality providers by making patients pay more out-of-pocket for higher priced providers – successfully shifts patients toward choosing lower-cost providers for all types of care studied. Reference pricing also reduced prices paid and total expenditures by insurers and employers.

The following five factors also made reference pricing more effective at lowering overall spending by insurers: 1) shoppable services – services that can be compared based on price and quality|2) measurable quality – quality that is easy to standardize|3) available information –price transparency and tools facilitating price comparisons|4) 'contestable' markets –competition between providers|and 5) accommodating regulators – for example, DHS allows patients in reference pricing plans to not count payments above the employer's contribution limit toward the deductible or annual out-of-

pocket maximums. The authors point out that reference pricing only works in situations where patients shop for a single healthcare service, and is ineffective at reducing costs of managing chronic illnesses.

2) Policies to Promote Healthcare Market Competition

Source Advisory Board member Paul B. Ginsburg, Martin Gaynor, and Farzad Mostashari published *Making Health Care Markets Work: Competition Policy for Health Care* (JAMA). They divide their policy proposals into three categories: 1) maintaining competitive healthcare markets|2) preventing anticompetitive practices by dominate players in the market|and 3) encouraging new competitor entry.

Maintaining Competitive Markets: The authors highlight the problem posed by the declining number of independent physician practices, as more hospitals acquire physician employees and combine competing practices. They suggest several policies to help maintain market competition in the face of this growing vertical integration. "Facility fees" should be eliminated when used to allow physician practices acquired by hospitals to charge higher rates for services typically performed outside of hospitals. DHS' 340B Drug Pricing Program, which allows hospitals to buy pharmaceuticals at lower prices than independent physician practices, should also be eliminated. To simplify the complex administrative burdens, such as quality payment programs and the Medicare Access and CHIP Reauthorization Act (MACRA), data collection and reporting procedures should be simplified, and the number of quality measures should be reduced and standardized. Value-based measures also shift risk to providers, and in turn can drive independent practices groups to join dominate health systems. Policies that help independent practices take on a reasonable amount of risk, such as those in MACRA, also allow those providers to remain independent from hospitals.

Preventing anticompetitive practices: The authors caution against legislation such as state cooperative agreement laws passed in West Virginia, which shield merging entities from antitrust review, unless antitrust entities agree that such measures are warranted. They also suggest increased scrutiny of acquisitions of physician practices by dominate health systems. Regulators should also keep a close watch on anticompetitive conduct, such anti-steering provisions in contracts. The authors also suggest that state regulators should use their power to regulate insurance rates to prevent anticompetitive conduct and promote price transparency.

Encouraging New Competitors by Removing Barriers to Entry: Finally, the authors argue that states should repeal certificate of need requirements, which limit the entry of new health care providers in local markets. States should also consider loosening restrictive licensing requirements, allowing more clinicians to offer care they are qualified to provide.

3) Chargemaster List Prices

In *Mystery Of The Chargemaster: Examining The Role Of Hospital List Prices In What Patients Actually Pay* (Health Affairs), Michael Batty and Benedic Ippolito uncover some of the mystery behind list prices on hospital chargemasters. The authors' research found that higher chargemaster rates led to higher final payments from patients and private insurers. Thus, hospitals likely set these rates strategically to generate revenue. Between 2002 and 2013, hospitals received on average an additional 15 cents in payment from private insurers for every additional dollar in list prices. In addition, the data showed that chargemaster rates and amounts paid for care varied greatly between hospitals and markets. The hospital a patient visited was most influential factor on the amount paid for care for a given diagnosis. The authors also compared data

from before and after the implementation of the California Fair Pricing Act, which capped payments from uninsured patients. They found that before the Act, hospitals received an extra 20 cents in payment from uninsured patients for every additional dollar in list price. After the legislation, that correlation essentially zero.

Fundamental hospital characteristics, such as size, for-profit vs. non-profit, location, also correlated with the chargemaster rates. For example, "a large for-profit hospital in an urban area that was a member of a chain had list price markups that were 360 percent higher than those of a small, independent, rural, nonprofit hospital." Interestingly, this study found that hospitals in more highly concentrated markets had lower chargemaster rates than hospitals in areas with lower concentration. However, private insurers also paid hospitals highly concentrated markets 2.6 percent more than those in more competitive markets. Given this data, the authors conclude that hospitals in more competitive markets drive the relationship seen between list prices and payments. Finally, the authors considered whether prices correlated with quality, and found a very limited relationship between price and quality of care.

4) ACA Enrollment

Timothy H. Callaghan and Lawrence R. Jacobs published *The Future of Health Care Reform: What is Driving Enrollment?* in the Journal of Health Politics, Policy, and Law. In their article, the authors explore the variation between states in enrollment in both ACA exchanges and Medicaid following the passage of the ACA. Their study analyzed whether the following six factors led to variation in enrollment figures: 1) partisanship (state party control)|2) presidential cueing (percent vote share for Obama)|3) administrative capacity|4) ACA policy decisions|5) affluence|and 6) unemployment rates.

Partisanship did not significantly influence the numbers of enrollees on ACA exchanges or Medicaid. Only two factors accounted for differences in ACA exchange enrollment, unemployment rates and presidential cuing. Higher unemployment rates had a negative and significant influence on exchange enrollment. Areas with a greater percent vote share for Obama also had greater relative exchange enrollment numbers. For Medicaid, enrollment was higher in states with Democratic legislatures, higher unemployment, expanded Medicaid policies, and stronger administrative capacity.

That’s all for this month. 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 spring reading!