Academic Articles & Reports Round-up: January 2016

As expected, a large number of articles and reports were published in January. Most heavily discussed was healthcare cost, which came up in many contexts, including: national spending slowdowns, comparatively among different countries' healthcare systems, pharmaceutical drugs, healthcare services, the effect provider education has on cost, how cost intersects with quality, "cost-effectiveness," and high-cost/high-need patient populations. Another hot topic was healthcare consolidation. One article discussed the general history and trajectory of healthcare consolidation (spoiler alert: it isn't slowing down anytime soon) and the California Health Care Foundation published a mini-series on healthcare consolidation in the San Francisco Bay Area. Other issues represented in January's literature review were third party payers, the promise esignatures hold in reducing insurers' administrative costs, certificate-of-needs laws, price transparency, and a case study on Oregon's health reform policies and initiatives. Enjoy!

HEALTHCARE COST

Generally

Health Affairs published an article, early in the month, explaining that the *Health Care Spending Slowdown From 2000 To 2010 Was Driven By Lower Growth In Cost Per Case, According To A New Data Source*. In their study, the authors analyzed the Bureau of Economic Analysis' 2015 Health Care Satellite Account data (which tracks national health care spending by medical condition) and conclude that the healthcare spending slowdown that occurred between 2000 and 2010 was a result of the reduction in growth in cost per case. More specifically, the authors found that more than half of the slowdown was a result of a decrease in spending on circulatory health conditions and that major slowdowns also occurred in the treatment of endocrine and musculoskeletal conditions.

In his book entitled *Health and Prosperity: Efficient Health Systems for Thriving Nations in the 21st Century*, Fabrice Murtin, an international economist at the

Organisation for Economic Co-operation and Development (OECD) wrote a chapter on "The Cost of Health." Murtin argues that the institutional framework of a country's healthcare system is what explains the differences in cross-country analyses in longevity. He reasons that the institutional framework of a country's healthcare system is associated with "systematic differences in the degree of cost-efficiency." Murtin also presents additional factors that are statistically associated with a higher degree of healthcare cost efficiency: stronger price regulation, health system decentralization, and a higher degree of competition among health providers and private insurers.

Pharmaceutical Drug Costs

The American Scientific Research Journal for Engineering, Technology, and Sciences published an article on the *Rising Cost of Prescription Medications and Effective Management of Healthcare Costs in the United States*. In the article, a Healthcare Management and Advisory specialist, explores the reasons why pharmaceutical drugs constitute such a large percentage of the United States' expenditure on healthcare costs, as well as possible solutions to this problem. The author argues that pharmaceuticals cost so much in the United States due to the high costs of research and development costs associated with new drugs|lack of consumer negotiating power|and practitioners buying drugs (e.g., chemotherapy), administering it in their offices, and upcharging patients for the drugs. The author argues that, in order to decrease pharmaceutical costs in the United States, the government needs to be able to negotiate drug prices on behalf of Medicare patients|the United States needs to allow individuals to purchase medications from other countries|the United States needs to make better use of generic drugs|and pharmaceutical prices need to be tied to their effect and the value they provide patients. Although the author may have effectively identified some of the reasons underlying the amount of money spent on pharmaceuticals, it remains to be seen whether such solutions would be practical or likely to occur under the United States' current healthcare system.

Healthcare Service Costs

The American Journal of Cardiology published an interesting and comprehensive

report that studied the *Association of Hospital Prices for Coronary Artery Bypass Grafting with Hospital Quality and Reimbursement*. The authors of this study were looking for potential reasons for the large disparities between hospitals, regarding out-of-pocket price estimates for coronary artery bypass grafting. The authors examined whether the 10-fold price differences among hospitals could be linked to hospital quality, geographic location, and/or reimbursement levels from major insurers. The only variable that was somewhat statistically associated with the price variance was geographic region|there was not a statistically significant association between service price and procedure quality or between service price and reimbursement rates.

The Effect of Provider Education on Healthcare Costs

Hospital Pediatrics published an article that contemplates ways of addressing healthcare cost and value in the pediatric field. In the article entitled, *Description and Evaluation of an Educational Intervention on Health Care Costs and Value*, the authors present data that shows that a pilot study at The Children's Hospital of Philadelphia showed that when physicians were provided healthcare cost and value data, they were more aware of the cost and value of their services, and they initiated conversations about the role physicians could play in decreasing cost and increasing value. The authors urge for more education, cost transparency, and decision support tools for physicians to support them in translating their cost and value knowledge into practice.

In a similar vein, BMJ Quality &amp|Safety published an article on the effects of *Displaying radiation exposure and cost information at order entry for outpatient diagnostic imaging: a strategy to inform clinical ordering*. This study, however, looked at the effect both cost *and* safety had on clinicians. The article concludes that displaying radiation exposure and cost information at the entry of an order for CT, MRI, and ultrasound services "may improve clinician awareness about diagnostic imaging safety risks and costs." Interestingly, in the study, clinicians were more influenced by the radiation information and resident physicians and nurse practitioners were more influenced by the cost of the services.

The Intersection of Cost and Quality

Smart Health published an article entitled *How Price Affect Online Purchase Behavior in Online Healthcare Consulting? Perceived Quality as a Mediator* [sic]. The article's authors examined the effect a healthcare practitioner's service prices had on patient purchasing behavior. The authors found that patient-perceived quality "has an incomplete mediating effect" on the impact of price—and subsequently on purchasing behavior.

Cost-Effectiveness Studies

Health Systems &amp|Reform published an article entitled *Departures from Cost-Effectiveness Recommendations: The Impact of Health Systems Constraints on Priority Setting*. This article explains the importance cost-effectiveness analysis could have on the future evaluation of healthcare interventions and the development of evidence-based clinical guidelines. The article further explains that budget constraints are the primary reason cost-effectiveness recommendations are not implemented, and that six other less often addressed constraints exist: healthcare system design, the cost of implementing a cost-effectiveness measure, system interactions between interventions, uncertainty in the estimates of benefits and costs, weak governance, and political constraints. The authors argue that each constraint must be identified by any decision maker who is seeking to implement cost-effectiveness measures.

Health Systems &amp|Reform then published a sister article that examines the challenges inherent in using cost-effectiveness thresholds to determine which services a third party payer will fund. In the article entitled *Using Cost-Effectiveness Evidence to Inform Decisions as to which Health Services to Provide*, the authors argue that three main issues challenge the use of cost-effectiveness in this context: (1) whether there is/are one or more thresholds that should be used and how the range of cost-effectiveness should be determined|(2) how health benefits can be assigned values|and (3) how to address and manage the tension between cost-effectiveness and the affordability and sustainability of health services. In sum, the authors conclude that, despite these challenges, cost-effectiveness thresholds are important. The authors also posit that quality-adjusted life years ("QUALYs") and the "opportunity cost in terms of the health benefits from displaced activities" may be appropriate ranges for identifying cost-effectiveness thresholds in the future. The

challenges facing cost-effectiveness definitions and determinations are reminiscent of the issues The New England Journal of Medicine identified in its November 2015 article on *Measuring the Value of Prescription Drugs*. In that article, the authors discussed that the move toward value-based frameworks for assessing drugs is a "positive step," while also acknowledging that value is an "elusive target."

High Cost/High Need Populations

Both the Commonwealth Fund and Health Affairs published articles on high-need/high-cost patients. The Commonwealth Fund published an article that illustrates *How High-Need Patients Experience the Health Care System in Nine Countries*. This article defines high-need patients as those individuals who use a disproportionate amount of health care services, and who usually suffer from clinically complex conditions, cognitive or physical limitations, or behavioral health problems. The article illustrates the similarities and differences high-need patients faces in Australia, Canada, France, Germany, the Netherlands, Norway, Sweden, Switzerland, and the United States. Examples of these comparisons include: number of chronic conditions, functional limitations, avoidable emergency visits, cost-related access problems, care coordination, patient confidence in their medical care, doctor-patient contact between visits, and the incidence of treatment plans.

In addition to the Commonwealth Fund's article, Health Affairs published a series of similar articles on High-Cost Populations, The ACA, And More. Here, the articles' authors discuss the effects that substance abuse, housing instability, mental illness, the job market, and ACA Medicaid expansion have had on high -cost patient populations.

HEALTHCARE CONSOLIDATION

Generally

The Northwestern University Soshnick Colloquium on Law and Economics published a paper, entitled *The Price Effects of Cross-Market Hospital Mergers*, written by Professors Leemore Dafny, Kate Ho, and Robin Lee—all of whom are also affiliated with NBER. In their paper, the professors examined the impact health care provider mergers had on negotiated prices with health insurers. To examine these impacts,

they used a theoretical bargaining-framework to show that "providers that are not direct substitutes at the point of care can negotiate higher prices with a common insurer following a merger if the providers share common customers (e.g., individuals, households, or employers) who value both providers." They also set forth conditions under which mergers between providers that share a common insurer (even absent customers), is sufficient to generate a price effect. The authors then tested their predictions in two acute-care hospital mergers contexts. Upon application, the professors arrived at a conclusion that "cross-market, within-state hospital mergers appear to increase hospital systems' leverage when bargaining with insurers."

Oncology Times published an article entitled *Capitol Hill Briefing: Consolidation in Health Care Likely to Continue*. The article predicts that the healthcare industry will continue to consolidate, at an accelerated pace and in all sectors. In the article, multiple legal, health, and economic analysts discuss the effects of past consolidation and postulate about the effects of future consolidation. The Source's Advisory Member, Dr. Paul Ginsburg, added to the conversation. Dr. Ginsburg stated that "[c]onsolidation in both provider and insurer markets is already extensive, and the trend will continue even without additional mergers." Dr. Ginsburg, along with Dr. Eric C. Schneider, Senior Vice President for Policy and Research at the Commonwealth Fund, argue that, in the current healthcare landscape it's "increasingly challenging to be a small hospital or medical practice" because there is pressure on reimbursements, there are new contracting models to consider, there is a demand for electronic medical records, and younger physicians are opting to join hospitals. Dr. Ginsburg further pointed out that providers who join networks are also affected|there is a trend toward provider networks and toward shifting the volume from high-priced to low-priced networks. Dr. Ginsburg is quoted in the article as urging a policy agenda to promote competition in this era of healthcare consolidation. The agenda, he states, should include: vigorous antitrust enforcement, support for independent hospitals and medical practices, and "wise policies on network adequacy and insurance exchanges."

California-Specific

The California Health Care Foundation (CHCF) published an issue brief entitled, *San*

Francisco Bay Area: Major Players Drive Regional Network Development. This article argues that, "large players" are consolidating hospital and physician organizations in the Bay Area. More specifically, the issue brief found that: (1) major Bay Area providers are expanding in an effort to manage care efficiently, to serve a larger population, and to compete with Kaiser|(2) the number of independent hospitals is shrinking as a result of financial issues|(3) independent practice associations are looking to diversify, raise capital, and keep private practices viable in the market|and (4) the Bay Area's "safety net is strong," but it is facing "serious capacity and access challenges" and is having difficulty recruiting and retaining physicians. The authors believe these challenges are a result of the ACA Medi-Cal expansion. Over the next several months, CHCF will publish a series of issue briefs that examine five other California healthcare market regions.

CHCF also published an article entitled *Empire Building by the Bay: Consolidating Control of Hospitals and Physician Organizations in the Bay Area*. In this article, CHCF provides an interactive infographic that depicts how Bay Area healthcare providers are forming "health care empires" by affiliating with key health players (e.g., Kaiser, Sutter, Stanford, and UCSF). Maps are available for all Bay Area counties, including San Francisco, Alameda, Marin, San Mateo, and Contra Costa counties.

In addition, CHCF published an article on Sacramento's healthcare sector. In it's article entitled *Sacramento: Pressures to Control Costs Persist Alongside Growing Capacity and Access Challenges*, CHCF describes Sacramento's healthcare landscape as "mostly stable" but argues that it has issues with capacity constraints and patient access. More specifically, CHCF found that: (1) while Kaiser is gaining inpatient market shares, in the Sacramento area, Dignity Health is losing inpatient market shares|(2) plans and providers have not been able to create narrow-network collaborations at the rate expected, which has made it difficult to sustain low-premium trends|(3) physicians have continued to consolidate|(4) Sacramento-area emergency departments faced overcrowding issues as a result of patients who lacked access to primary and urgent care, as well as from patients with mental health needs|and (5) the area's "safety net" improved in terms of cohesion and coordination, but it was not as strong as other California safety nets. Over the next several months, CHCF will publish a series of issue briefs that examine five other

California healthcare market regions.

PAYER COSTS

The Proposed "Big 5" Insurance Mergers

The Center for American Progress published an issue brief, entitled *Bigger Is Not Better: Proposed Insurer Mergers Are Likely to Harm Consumers and Taxpayers*, in which the Center explains some of the potential impact the Aetna-Humana merger could have on the Medicare Advantage market. The Center argues that the Medicare Advantage market should be considered a separate market from traditional Medicare. If analyzed as distinct markets, the Center argues that the Aetna-Humana merger would result in greater concentration of the Medicare Advantage market (with more than 25% of the market served by Aetna). The Center further argues that even if the federal government requires Aetna and Humana to divest parts of their Medicare Advantage businesses in areas where they overlap, the merger would still reduce competition and would, ultimately, result in higher premiums for seniors and higher costs for the Medicare program, overall.

Medical Loss Ratio Constraints

Ombud, Inc. published an article entitled *How Healthcare Payers Exceeded Federally-Mandated Medical Loss Ratio With eSignatures*, wherein Ombud explains what the Medical-Loss Ratio is|presents a map of the average health payer rebates, in 2012, by state|and uses Iowa as an example of how states can regulate health premiums and increase transparency surrounding insurance premium increases. Iowa subjects insurance companies that plan to increase their premiums to public hearings and requires that the companies personally notify plan members of any rate increase and the purpose of the increase. The article also uses Wellmark Blue Cross Blue Shield of Iowa to show how much an insurance company can save in administrative fees by implementing esignature software. According to HHS, "Iowa saved 6,929 consumers in the small group market $1,125,000 last year" and argues that "[e]ach payer could save that amount with electronic signatures."

HEALTHCARE ACCESS

The George Mason University Mercatus Center published a working paper that asked the question, *Are Certificate-of-Need Barriers to Entry? How They Affect Access to MRI, CT, and PET Scans* [sic]. The authors, a George Mason University Professor of Economics and Law and a PhD student, compared the effects of certificate-of-need ("CON") laws on imaging services (MRI, CT, and PET scans) provided by hospital providers and by nonhospital providers. The authors conclude that CON laws are negatively associated with the number of imaging services provided by nonhospital providers—and not negatively associated with imaging services provided by hospital providers. The authors also find that CON laws reduce the overall number of medical providers, which decreases the availability of imaging services in states with CON laws, and that this subsequently results in residents of CON law states travelling outside of the state to obtain imaging services. The authors ultimately conclude that CON laws affect the market structure for imaging services and that these effects are heterogeneous between hospitals and nonhospitals.

PRICE TRANSPARENCY

Just after the turn of the new year, the Journal of Oncology Practice published an article entitled *Improving Price Transparency in Cancer Care*. The article's authors liken the United States' healthcare system to a "menu without prices"—for both patients and physicians. The authors argue that this type of "firewall" pricing system may have served an ethical purpose in the past, but that in an era of rising cancer care costs and patient cost sharing, it no longer serves a purpose and should therefore be modified.

ADDITIONAL ARTICLES

The Urban Institute's Health Policy Center did a *Health Care Stewardship* case study on Oregon's history of healthcare reform initiatives.

See you next month!