Academic Articles & Reports Round Up: May 2016

Happy June! In May, healthcare scholars discussed the usual topics of healthcare price, transparency, and hospitals. And, since the third open enrollment period ended February through April 2016, journals and foundations published multiple reports and articles on state marketplaces. Enjoy!

HEALTHCARE PRICE

The Journal of Applied Clinical Medical Physics published an article that seeks to answer the question: *Why is health care so expensive in the United States?* In this op-ed, the author, a "medical physicist" presents his opinions on why healthcare is so expensive in the United States. He attributes high healthcare prices to four majors sources: (1) non-governmental healthcare systems and their reliance on loans from large financial institutions|(2) the assumption that healthcare systems' debt is passed onto patients|(3) insurance company antitrust exemptions (*see* the McCarren-Fergusen Act)|and (4) the fact that CMS does not negotiate bulk drug prices with pharmaceutical companies. The author himself acknowledges the level at which this think piece oversimplifies the complex concepts underpinning healthcare prices in the United States.

EMPLOYER-SPONSORED PRICE TRANSPARENCY TOOLS

JAMA published an article that *Price Transparency: Not a Panacea for High Health Care Costs*, wherein the author discusses the positive effect state healthcare price transparency initiatives have had on patient spending. The author cites a statistic that more than half of U.S. states have passed price transparency legislation (*see* The Source's Legislation/Regulation webpage and Issue Brief on these initiatives). The author examined one employer-sponsored

private price transparency tool and found that it was associated with lower claims payments for common medical services (1-14% reductions, based on procedure).

On the other hand, JAMA also published an article that found no significant association between employer-sponsored price transparency tools and healthcare cost savings. In *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, the article's authors analyzed employee use of price transparency tools in two large employers, in 2011 and 2012. The authors compared employees who used the tools and those that did not. The study measured annual patient spending, outpatient out-of-pocket spending, and usage rates to determine whether the tools affected employee healthcare spending. Unlike general price transparency initiatives, the authors found that (1) that only a small percentage of employees used the employer-based tools, and (2) use of the tools was not associated with lower employee healthcare spending.

STATE MARKETPLACES

Health Affairs posted an article on *Differing Impacts Of Market Concentration On Affordable Care Act Marketplace Premiums*. The article's authors, which include Richard Scheffler, studied the impact market concentration had on two state insurance marketplaces: Covered California and NY State of Health. Using the widely-used Herfindahl-Hirschman Index ("HHI") tool, the authors measured premium growth and its relationship to health plan, hospital, and medical group market concentration. The authors found that (1) both state marketplaces exhibited a statistically significant positive association between hospital concentration and premium growth|(2) both states exhibited a positive—but not statistically significant—association between medical group concentration and premium growth|(3) a positive association between health plan concentration and premium growth in New York|and (4) a negative association between health plan

association between health plan concentration and premium growth in California.

McKinsey on Healthcare published an article entitled *Exchanges three years in: Market variations and factors affecting performance*. The authors analyzed the most recent (third) open enrollment period for the state exchanges and determined that, since their inception, they have changes in four key areas. The authors found that: (1) the overall individual market suffered a $2.7 billion loss in 2014, with performance varying among the states|(2) that insurance carriers that earned a positive margin in 2014 shared common factors, including narrow networks and managed care designs|(3) that early 2015 results varied—some carriers earned profits and some suffered losses|and (4) due to market-stabilizing subsidies, insurance "death spirals" are unlikely to occur. The authors predict that these observations will require state marketplace insurers to modify their business models in order to successfully compete in their respective marketplace.

The Commonwealth Fund published a report on *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*. The Commonwealth Fund surveyed Americans and found that, by the end of this third open enrollment period, most ACA enrollees have used their plans to obtain healthcare services that they normally would have forgone. The report also noted that the number of uninsured Americans is 12.7%, in 2016, which is not statistically significantly different from 2015. The report further states that uninsured rates have fallen steeply in he past three years and most steeply in low-income adults. In this same vein, the report indicates that 82% of adults who obtained ACA marketplace coverage or who were newly enrolled in Medicaid were satisfied with their insurance.

HOSPITAL PROFITABILITY

Health Affairs published an article entitled *A More Detailed*

Understanding Of Factors Associated With Hospital Profitability. Here, the authors identified some of the lesser-known characteristics of the most profitable hospitals by measuring hospital profits from patient care services per adjusted discharge. The authors found that 45% of U.S. hospitals are profitable and identified higher markups, system affiliation, regional power, and hospitals located in states with price regulation as four major indicators of hospital profitability for for-profit institutions. Lower profitability was associated with higher expenditures per discharge, being located in a county with a high number of uninsured individuals, having a large number of Medicare patients, and being located in a state with a dominant provider/HMO penetration.

See you next month!