Academic Articles & Reports Round-up: October 2015

We hope everyone had a Happy Halloween! October provided a high volume of articles focused on an array of topics related to healthcare price and competition, so bear with us! One JAMA article, in particular, provided an umbrella view of the October healthcare literature. The article, entitled *Insurers Again at Odds With Hospitals and Physicians*, provides a historical analysis of the tension between health insurers and physicians/hospitals/pharmaceutical companies from the perspective of Harvard Economics Professor David M. Cutler, PhD. Dr. Cutler argues that what's at the heart of the United States' healthcare cost argument is not the oft-maligned ACA, changing information technology (IT) standards, or quality reporting burdens, but rather the jockeying for control over healthcare. This perspective, published early in October, foreshadowed the literature published throughout the rest of the month, which highlighted the relationships among healthcare entities, offering a breadth of historical and geographic analyses.

Yale Symposium

In the beginning of October, the Yale Journal of Health Policy, Law, and Ethics devoted its entire Volume 15, Issue 1 to its symposium on the fiftieth anniversary of Medicaid and Medicare. Ezekiel Emanuel began the symposium with opening remarks on why Medicaid and Medicare are structured the way they are, how they were implemented, the politics underpinning each program, and what he believes is necessary for Medicare's continued viability: payment reform. Other keynote speakers, including one of the Source's Advisory Board Members, Tim Greaney, discussed where Medicaid and Medicare started and where they may go. Other speakers discussed various issues relevant to both Medicaid and Medicare, including: Medicaid and Medicare's legal landscape, two articles on long-term care (the expansive reverberations of long-term care in communities and the necessary, yet absent, components of long-term care), Medicaid and Medicare's potential roles in pharmaceutical innovations, and the programs' gaps in regard to disabled Americans. Professor Greaney began the discussion of Medicare by providing insight

into the traditional Medicare, Medicare Advantage, and ACO delivery models and their potential trajectories. Other speakers discussed Medicare in the context of: the evolution of Medicare administrative law and why Medicare has not become Medicare-for-all. Other speakers spoke about the Medicaid program, generally, its progression from fragmentation to universality, new Medicaid eligibility requirements, Section 1115 waivers, Section 1332 waivers, and Medicaid's potential future as it intersects with private health insurance.

Healthcare Cost Variations

At the forefront of issues discussed in October were healthcare cost variations across geographic regions. In its blog entitled *Analysis Details Most and Least Expensive Cities for Common Medical Services: Pricing for the Same Medical Services is All Over the Map (Literally)*, Castlight Health illustrates, via interactive maps, the vast price variations in lipid panels, preventive primary care visits, head/brain CT scans, and lower back MRIs across the United States. A HealthAffairs article entitled *Less Physician Practice Competition Is Associated With Higher Prices Paid For Common Procedures* added to the price variation conversation by discussing the effect physician practice concentration has on healthcare pricings. The article detailed a study led by a Stanford School of Medicine graduate and a Stanford Health Services Research Professor that found that physician practice concentration and healthcare prices were significantly associated for 12 of the 15 most common, high-cost procedures. The study further found that healthcare prices for counties with the highest average physician concentration were between 8 and 26% higher than prices in the lowest counties. The authors suggested that physician practice organizations consider the results of this study when choosing physician location.

In a similar vein, the Kaiser Family Foundation (KFF) looked at Medicare billing and reimbursement variations across the United States. KFF published an article analyzing *The Latest on Geographic Variation in Medicare Spending: A Demographic Divide Persist But Variation Has Narrowed*. The report analyzes unadjusted and adjusted average per capita Medicare rates by highest spending counties, lowest spending counties, and geographic location. The report states that, that, in 2013, the national unadjusted average per capita spending for Medicare was $9,415|the

unadjusted average in the twenty lowest spending counties was $6,726|and the unadjusted average of the 20 highest spending counties was $13,149—twice as high as that of the lowest spending counties. The report shows that the majority of the highest unadjusted counties were in the northeast, mid-Atlantic, and southern regions, whereas the majority of the lowest spending counties were in western states. KFF points out that the areas of the country with the highest unadjusted Medicare spending were areas where poor health, poverty and high healthcare prices are prevalent. KFF concludes then that "changing provider practice patterns may help to curtail spending growth and reduce variation in spending across counties but will not eliminate the abiding socioeconomic, demographic, and health disparities between the highest- and lowest-spending counties." The study continues on, however, to show that adjusting these averages for price and health-risk differences narrows the variation to a mere $1,704 and shifts the regional concentrations. Once adjusted, all but one of the 20 highest counties were located in the southern states, and almost all of the lowest counties remained in the western states. Also of note is the fact that county-level geographic variations in Medicare per capita spending began declining in 2009. The report ultimately is not conclusive on the drivers behind the spending: "[i]n light of our finding that counties with the highest price- and health-risk adjusted per capita spending have a larger supply of certain types of providers, including post-acute care providers, the question remains whether higher spending in these areas is driven by medical practice styles or by demand for care from a relatively sicker beneficiary population, or some combination of both. Further research is needed to understand this relationship."

October articles also discussed cost containment measures in various contexts and targeting various healthcare players. For instance, the Atlantic Economic Journal published an article on *The Impact of Market Share on Health Insurance Premiums*, which explored the proposition that health insurance premiums would decrease significantly if state insurance markets were more competitive. Furthermore, JAMA published *Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices*. The authors conducted a study that reviewed 240 metropolitan statistical areas (MSAs), between 2008 and 2012, and found that financial integration between hospitals and physicians were associated with increased commercial prices and spending in the outpatient care setting. Another

study, published in the Journal of Hospital Medicine, investigated *the Impact of price display on provider ordering: A systematic review*. The investigators found that when providers were presented with prices for lab tests, imaging studies, and medications, patient costs decreased by a "modest degree" and patient safety "appeared unchanged." The authors admit, however, that the evidence was limited and that additional, high-quality evidence is required to confirm their findings.

In regard to price increase variations across healthcare delivery systems, an article published in Health Affairs found that *Price Increases Were Much Lower In Ambulatory Surgery Centers Than Hospital Outpatient Departments In 2007-12*. The authors found that prices at ambulatory service centers (ASCs), unlike hospital prices, which increased sharply between 2007 and 2012, grew less sharply and more in line with general medical care prices. The authors' findings do not indicate that ASCs are successfully pressuring hospital outpatients departments to decrease their prices. Instead, the authors conclude that their findings "question the wisdom of using a single ratio for ASC payments to hospital outpatient departments."

Focus on State Cost Containment Models

A few October articles focused on state-specific models for containing healthcare costs and improving patient access. For example, Insights to a Changing World Journal reviewed Maryland's all-payer system in an article entitled *All Payer Regulations In Maryland Hospitals*. The article's authors found that Maryland's all-payer system has benefited Maryland (e.g., by keeping hospital costs "under control," decreasing length of hospital stays, and increasing health measures). While the authors urge other states to implement all-payer systems, they also aptly caution that all-payer systems are not one-size-fits-all|i.e., although Maryland's system works well in Maryland (a small state with large populations concentrated in urban areas), it may not be as successful in larger states or rural areas. Additional research is required to build all-payer systems that work for individualized state needs, population densities, and provider concentrations. On a similar note, the Duke Journal of Health Politics, Policy and Law published an article that reviewed *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*. The study found that medical group and hospital concentration in California was positively associated with the variation in Covered California's premium rates in the

rating regions. Concentration of health plans, however, was not statistically significant. As such, the experimenters concluded that reducing hospital concentration levels to those levels that would exist in moderately competitive markets would decrease premiums by 2%, and that in three of the 19 regions, the reduction would be as high as 10%. Lastly, the Journal of Women's Health, published an interesting article, *Taming Healthcare Costs: Promise and Pitfalls for Women's Health*, premised on the concept that women are often the primary decision makers for their families' healthcare needs. This paper looks at healthcare cost containment through the Massachusetts cost containment law, Chapter 224. The authors offer four approaches that show promise for maximizing women's access to comprehensive, quality healthcare while avoiding the potential for adverse effects on women's health.

Safety-Net Hospitals

A couple articles also focused on safety-net hospitals, their role in healthcare, and factors that affect their viability. The NBER published an article on *Private Safety-Net Clinics: Effects of Financial Pressures and Community Characteristics on Closures*. The article detailed a study that found that lower income from patient care, smaller amounts of government grants, and lower productivity threatened safety-net viability and caused safety-net clinic closures. In addition, the GAO published a report entitled *Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality-of-Care Trends*, which concluded that safety-net hospitals had lower median payment adjustment (smaller bonuses and larger penalties) than hospitals, overall. The report further showed that these gaps did, however, narrow over time and although there was no shift in performance quality measures, they could emerge in the future as the hospital value-based purchasing (HVBP) program evolves. The report also looked into quality measures and found that the most common challenge cited by hospital officials, as obstacles to increasing quality, were IT systems (e.g., EHR, etc.).

Cost-Sharing

Another heavily discussed topic was cost-sharing. In addition to its symposium on Medicaid and Medicare, the Yale Journal of Health Policy, Law, and Ethics published

an article entitled *Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security*. The article discussed the disparity between underinsured lesser-paid American workers and overinsured higher-paid workers and how this increases inflation. The authors argue that employers should scale cost-sharing wages and that, unlike most discussions of cost-sharing, their "novel analysis shows that [the ACA] gives the Internal Revenue Service the authority to require scaling and to thereby eliminate the current inequities and inefficiencies caused by the tax distortion." The NBER also weighed in on cost-sharing by publishing an article discussing *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*. Here, the article's authors studied a large, self-insured firm as it switched its insurance from a plan that offered employees free health care to a non-linear, high deductible plan. The study found that the switch (1) resulted in a spending decrease of 11.79-13.80%|(2) showed no evidence that consumers learned how to price shop after two years|(3) and showed that consumers reacted "heavily" to spot pricing at the time of service and reduced their healthcare spending by 42% when still under their deductibles, conditional on their respective plans' true expected end-of-year shadow price and the prior year's end-of-year marginal price.

Competition

Carrying over from September, insurer and provider competition remained at the forefront of healthcare discussion. In regard to insurer competition, economics professors Kate Ho and Robin S. Lee published an article, *Is health insurance good for consumers?*, in the London School of Economics Blog. The authors argue that reduced insurer competition raises negotiated hospital prices in some geographic areas and decreases hospital prices in others and that the result depends on which insurer is removed from the market. They further conclude that decreased insurer competition could result in hospital service price reduction (if the exiting/merging insurer is large enough) but that these savings may not necessarily be passed on to consumers if insurer premium mark-ups are insufficiently constrained. A topic on the fringe of health insurance competition issues is Medicare transitions—that is, whether Medicare members freely transition between traditional Medicare and Medicare Advantage. An interesting article, *High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage And Joining Traditional Medicare* published in

Health Affairs, discussed the extent to which Medicare members transition between the two programs. The authors found that from 2010 to 2011, Medicare members who used long-term nursing home care, short-term nursing home care, and home health care were more likely to switch from Medicare Advantage to traditional Medicare than from traditional Medicare to Medicare Advantage. They concluded that their "findings raise questions about the role of Medicare Advantage plans in serving high-cost patients with complex care needs, who account for a disproportionately high amount of total health care spending." Their findings may also have implications for state and federal reviews of the proposed Anthem/Cigna and Aetna/Humana insurance mergers.

In regard to provider competition, professors of economics, law, and public health—including the Source's Executive Editor, Jaime King—teamed up with UCSF medical school to write *State Actions to Promote and Retain Commercial Accountable Care Organizations*. The authors discuss how ACOs have the potential to improve healthcare quality, patient outcomes, and cost savings, as well as the risks associated with ACO solvency and anticompetitive pricing. The authors analyze four case studies and literature to provide tools state governments can use to mitigate ACO risks and promote ACO benefits. In the second part of the paper, the authors apply their proposed tools to California, a large state with a rapidly growing ACO market.

The NBER published an article that intersects provider competition and Medicare: *Effects of Payment Reform in More versus Less Competitive Markets.* The authors, using Medicare claims, found that although providers in more competitive markets had higher average costs in the pre-reform period, these more competitive markets experienced larger proportional reductions in treatment intensity and costs after the reform relative to the lesser competitive markets. This, the article's authors argue, resulted in a convergence in spending across geographic areas. The authors concluded that much of the reduction in provider costs is driven by the exit of "high-cost" providers in the more competitive healthcare markets.

Miscellaneous

Also of note in October's literature were findings that organizations are using

healthcare coverage and other benefits offerings as leverage to recruit, hire, and retain employees.

See you next month!