The Source Roundup – January 2018 Edition

By: Briana Moller, Student Fellow

Happy New Year! In this Roundup, we cover four articles from November and December 2017. The topics include 1) the rising cost of emergency care, 2) promoting price transparency through contract law, 3) the move towards value-based payment systems, and 4) government regulation to control prescription drug prices.

Rising Cost of Emergency Care

As a part of a year-long investigation, Vox, working alongside the Health Care Cost Institute ("HCCI"), investigated the recent phenomenon of increased emergency room prices. In "Emergency Rooms Are Monopolies. Patients Pay the Price," author Sarah Kliff uses the findings and examines how spending on facility fees have steadily increased despite a decline of the amount of emergency room visits. Facility fees are the price of visiting the emergency room itself. These fees are typically coded on a 1-5 scale depending on the complexity of care the patient receives. Hospitals have broad discretion in determining what level to assign each visit, a difference that could amount to hundreds of dollars for a patient. The HCCI found that not only did prices of facilities fees rise 89% from 2009-2015, but there's also a noticeable trend of providers using more expensive billing codes. Their research shows that more visits were labeled Code 4 or Code 5 than ever before. Although some providers attribute the increased code labeling to a rise in more severe emergency cases, this article suggests that providers' monopoly-like control over this area of health care is the likelier explanation. With little regulation of providers' broad discretion and little incentive to stop, the market is unlikely to resolve the issue itself. Therefore, Kliff calls upon policymakers to take the matter into their own hands and start to prioritize patients over profits.

Health Care Organizations Make the Switch to Value Based Payment Systems

In "Economic Investment and the Journey to Health Care Value," a three-part series for the NEJM Catalyst, authors Jeff Micklos and Caitlin Sweaney track the switch of various health care organizations to value-based payment systems, and report from the perspectives of 1) providers, 2) payers, and 3) purchasers that are making the transition. In a nutshell, a value-based payment system focuses on results rather than individual services provided. In contrast to fee for service models, value-based payments systems look at health outcomes and data in the aggregate and pay for performance.

From a provider's perspective, switching to a value-based system means changing infrastructure– adding a variety of resources available to patients, from improved nurse management to social and behavioral support. In their transition, providers have improved IT infrastructure to not only increase efficiency and streamline care, but also to analyze data and manage larger health populations and outcomes. While it is too early to predict the ultimate impact of these changes, early evidence shows that transitioning to value-based systems brings providers financial savings. Most notably, when the Center for Medicare and Medicaid Services' Accountable Care Organization switched to a value-based payment system, it generated more than $405 million in savings over the course of five years.

Health care payers also found that value-based systems save them money. The article notes that as opposed to fee for service systems, value-based systems reduce insurer costs and overutilization. Many commercial players are building new infrastructure and transitioning many of their provider contracts to value-based contracts. As of August 2017, 184 value-based provider contracts have been announced among 5 large companies, including Cigna and Humana. However, insurers still face challenges such as market instability and uncertain return on investment in implementing strong programs. The authors stress that it is therefore important to sustain the momentum toward value-based care.

Finally, the article examines different approaches to value-based purchasing.

Healthcare purchasers implement value-based systems through various programs including Centers of Excellence, employer coalitions, bundled payments, and reference pricing. These programs are becoming increasingly popular with large companies due to significant savings from implementation. For example, large employers such as Walmart, Lowes, and JetBlue saved $5 million annually and improved patient outcomes through bundled payment programs. CalPERS also saved $31 million through reference pricing implementation. The article points out that as purchasers of healthcare, employers have the ability to drive change. The momentum of value-based purchasing will continue as more organizations recognize its benefits.

Using Contract Law to Promote Price Transparency in Health Care

In *Price Transparency and Incomplete Contracts in Health Care* (Emory Law Journal), Wendy Netter Epstein asserts that the solution to the lack of price transparency in the U.S. health care system lies within contract law. Most medical procedures operate as open price contracts – patients typically agree to receive care without knowing the price. It's no secret that this lack of transparency harms consumers, in some cases causing debt or bankruptcy. As a solution, Epstein suggests that courts impose a default penalty in open price contracts. If a provider fails to specify the price of the procedure, thus leaving the contract incomplete, courts would fill in the gap with a price of $0. Esptein acknowledges that there are situations in which providers might not know the exact cost of treatment beforehand, such as some emergency visits or complex surgeries. Thus, she proposes a three-factor test to determine whether a contract should be complete. The first factor courts should consider is transaction costs. In some contracts, the overall gain from the contract itself would be outweighed by the cost of detailed drafting, making incomplete contracts more desirable. Second, courts should assess whether there's "information asymmetry." If one party has more access to information and experience than the other, the need for contract completeness is greater. Third, courts should consider whether the parties desire to create relational capital. If the goal of the parties is to build a relationship and foster trust (in situations such as providing an ongoing service or collaborative projects), having

open price contracts may be tolerated. However, if the goal of the contract is compliance, complete and detailed contracts are desired. In consideration of all three factors, Epstein argues quite convincingly, that most medical contracts would favor completeness.

Government Regulation as a Solution to Prescription Drug Price Hikes

In *The EpiPen Problem: Analyzing Unethical Price Increases and the Need for Greater Government Regulation* (University of Miami Business Law Review), author Talal Rashid discusses the problem of high prescription drug prices in the U.S. and offers solutions from other countries. Rashid first explores causes of the Epipen price hike, which range from the FDA generic drug approval backlog[1] to the no longer legal tax inversion tactics used by Mylan, Epipen's manufacturer. Rashid then looks to other countries where the governments employ methods to negotiate prices for prescription drugs, resulting in much lower prices. However, in order to allow manufacturers to regain their investments from research and development (R&D), Rashid suggests that the U.S. government negotiate prices for *off-patent* drugs only. Rashid also suggests that that the U.S. set up an independent review board similar to Canada's Patented Medicine Prices Review Board, in which the government would monitor and set prices of prescriptions drugs by comparing them to other countries. Next, Rashid suggests that the U.S. implement an evaluation process like those in Switzerland and France, which assesses therapeutic value, negotiates prices with manufacturers, and forms a contract that includes rebates and price re-evaluations. Lastly, Rashid suggests that the U.S. implement methods that encourage transparency. Specifically, the government should have access to R&D data, and manufacturers should be required to justify price increases and provide an explanation for the new price.

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 reading!

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1) Sydney Lupkin, EpiPen Controversy Fuels Concerns Over Generic Drug Approval Backlog, KAISER HEALTH NEWS (Sept. 6, 2016), http://khn.org/news/epipen-controversy-fuels-concerns-over-generic-drug-approval-backlog/.