January Articles & Reports Round Up

As the holidays faded, January rang in 2015 with a return to concern about health care costs and the role of the market in health care.

A number of reports came out this month on national costs. First and foremost, Health Affairs published *National Health Spending in 2013: Growth Slows, Remains in Step with the Overall Economy* in its January, 2015 issue. This annual report highlights national spending from the most recent data from CMS Office of the Actuary. In 2013, the U.S. spent $2.9 trillion on health care, about $9,255 per person. The report provides an excellent overview of how much we spent and on what in 2013. In the same issue, Mary K. Catlin, John A. Poisal, and Cathy A. Cowan published *Out-of-Pocket Health Care Expenditures, by Insurance Status, 2007-2010*, which provides detailed data on out of pocket spending on health care in the years leading up to the passage of the ACA. Next, Blue Cross Blue Shield published its *Health of America Report*, exposing what the national insurer called "tremendous, seemingly random variation in costs" for knee and hip surgeries around the country. The report demonstrated that charges for the same medical procedure could vary by tens of thousands of dollars even within the same metropolitan market. Furthermore surgical costs varied up to 313% depending on where the surgeries were performed. Although the Dartmouth Atlas has been publishing data on variation in Medicare reimbursements and usage patterns for decades, data on the variations in charges to a private insurer have been harder to come by.

The American Journal of Law, Medicine and Ethics dedicated its January issue to the Buying and Selling of Health Care. While the entire issue is worth a look, I will highlight a few of the most interesting articles. First, Andrew Wicks and Adrian

Keevil contributed *When Worlds Collide: Medicine, Business, the Affordable Care Act and the Future of Business in the U.S.* in which they argue that business is not the enemy of medicine, rather that business and medicine should and must go hand-in-hand in the U.S. However, they argue for a broader analysis of the practice of medicine via the "stakeholder theory" from business ethics. Stakeholder theory can be used to reframe the discussion around business and ethics from one where considering ethical concerns is viewed as optional to one where ethics and business are "inseparable and mutually reinforcing." Wicks and Keevil argue that bringing this kind of dedication to mission and values in the business of health care can inform discussions about the creation of an ideal health care system. In contrast, Jonathan Oberlander argues in *Between Liberal Aspirations and Market Forces: Obamacare's Precarious Balancing Act* that America's unusual reliance on market forces in our healthcare system has produced "dismal outcomes." The article focuses on the challenging duality that the ACA tries to achieve – namely moving the U.S. health care system away from the free market by subjecting market institutions to government regulation, while at the same time relying on, indeed even embracing, market forces to achieve many of its most important aims. It's an interesting read on the political forces at work in our health care system. Finally, Howard Brody wrote *Economism and the Commercialization of Health Care*, which examines the evidence that payment for performance (P4P) models work to improve value in health care. He argues that there are empirical and theoretical reasons to be suspicious of P4P schemes when applied to individual providers, as recent data demonstrates that the cost of implementing a P4P program often outweighs cost savings, physicians do more of what is being measured, but less of other things that affect the quality of care, and such programs may result in physicians attempting to game the system by refusing to treat the sickest and most vulnerable patients.

Outside of JLME, Zirui Song and David Chokshi discussed their opinion on *The Role of Private Payers in Payment Reform* in the January 6th issue of JAMA. The article examines the recent trend toward the private ACO model – private payers partnering with health delivery systems (like the recent Anthem Blue Cross union with seven Los Angeles delivery systems) in an effort to control health care costs. This trend represents a trend away from fee for service payments in favor of bundled and global payment agreements. The article compares the private ACO model with the public ACO model under Medicare and argues that in the future public-private partnerships may offer a beneficial compromise between regulatory and market attempts to control costs. Also on ACOs, Rudy Douven, Thomas MacGuire, and Michael McWilliams published *Avoiding Unintended Incentives in ACO Payment Models,* in the January issue of Health Affairs, which notes that the incentive structure in ACOs is to decrease spending from prior benchmark years. As a result, ACOs have a greater incentive to spend more money in benchmark years to avoid facing more restrictive savings goals. The authors suggest alternative weighting schemes and spending targets based on other ACOs and Medicare provider data.

For those of you interested in the narrow networks debate, in the January 5th issue of JAMA Internal Medicine, Katherine Baicker and Helen Levy published their opinion piece *How Narrow a Network is Too Narrow*?. The article examines the ambiguous requirements for provider networks in Exchange plans, and how the narrow networks that appeared in many of the 2014 Exchange plans left patients upset giving rise to numerous law suits around the country. As a result, South Dakota passed an "any willing provider" law last November, which requires insurance plans to include any qualified provider who is willing to care for patients for a given negotiated price. Any willing provider laws greatly limit the ability of any plan to narrow its network. Narrow networks can

be so narrow as to preclude access to care for many patients, but an overly broad network can limit an insurance company's ability to steer patients to high quality providers and effectively negotiate for lower rates with providers. Baicker and Levy argue that we need better tools to measure network adequacy and better network information for consumers to help them navigate the types of plans on the exchanges.

Health Affairs' January Variety Issue also had a number of interesting articles on a range of issues. Again, the whole issue is worth checking out, but here's a sampling. Ge Bai published *California's Fair Pricing Act Reduced the Prices Actually Paid by Uninsured Patients*, which documented a reduction in actual prices paid by the uninsured from 6% over Medicare prices to 68% under Medicare prices from 2004-2012. California's Fair Pricing Act prohibits hospitals from charging chargemaster prices to low and moderate income uninsured patients. Bai argues that this law should be a model for other states and the federal government seeking to provide similar protection to the uninsured. Erin Taylor and colleagues published *More Choice in Health Care Marketplaces May Reduce the Value of Subsidies Available to Low Income Enrollees*, the reason being that while premiums are capped, deductibles are higher in more competitive markets with more than 13 silver plans. As a result, in these more competitive markets, deductibles may be a more salient measure of plan value than premiums. Finally, Avi Dor, William Ecinosa, and Kathleen Carey reported that *Medicare's Hospital Compare Quailty Reports Appear to Have Slowed Price Increases for Two Major Procedures*.

That's it for the Roundup this month, Happy Reading!