May Articles & Reports Roundup

Greetings! For the academics among us, its time to wrap up your end of the year grading and see what you've been missing in the literature this month. Two themes came out of the literature in May. First, (no surprise to anyone) the American public continues to be frustrated with the lack of transparency and rationality in healthcare prices, but there are some signs of hope. Second, policymakers and academics have proposed numerous payment reforms, which despite their varying degrees of success, only get at a fraction of the problem. We'll start with the frustrations, and move into solutions.

Consumer Reports conducted a *Surprise Medical Bills Survey* that examined how the American public felt about their insurance providers and the impact of surprise medical bills. Seven out of ten Americans would give their insurance plan a B or higher, but not surprisingly, unexpected medical bills substantially lowered their satisfaction rates. The survey revealed that about 30% of consumers had received a surprise bill in the last two years, and while about a third of them would contact the insurance plan to dispute the charge, very few were satisfied with the result. Further, almost no consumers contacted government agencies for assistance. Chrissie O'Neill's article, *Medical Balance Billing: Inadequate Regulations, Increasing Consumer Outrage, and Competing Economic Interests – How Do We Fix It?*, explored the outrage that results from balanced billing practices, when providers charge patients for the portion of bills that remain after insurer reimbursement, and recent legislation in Texas and New York protect patients against such practices. On the upside, The Urban Institute's Michael Karpman and Sharon K. Long published the results from their survey *9.4 Million Fewer*

Families Are Having Problems Paying Their Medical Bills, in which they found that between September 2013 and March 2015 the share of families having problems paying their medical bills fell by 21.3 million. Perhaps these are initial signs of improvement following the implementation of the ACA, but there are still many more mountains to climb in terms of fixing our ailing healthcare system.

In terms of mountains, payment reform might as well be Mt. Everest, but everyday there are those who try to climb it. Topping the list of payment reforms discussed this month was *The Repeal of Medicare's Sustainable Growth Rate for Physician Payment.*, which Robert Steinbrook nicely summarizes in last week's JAMA. (May 26, 2015). Steinbrook notes that the repeal of the SGR "should accelerate the movement away from constrained fee-for-service payments toward continued payment reforms." He also describes the implications of the Medicare Access and CHIP Reauthorization Act of 2015 for physician payments for the next few years – a .5% increase for the second half of 2015 followed by .5% for each year from 2016 to 2019. In 2019, a new incentive payment program – Merit-Based Incentive Payment System (MIPS) – will consolidate three existing incentive payment programs: the Physician Quality Reporting System, the value-based payment modifier, and the meaningful use of electronic health records.

Also in JAMA, David Nyweide and colleagues published in the May 4th issue, *Association of Pioneer Accountable Care Organizations v. Traditional Fee for Service With Spending, Utilization and Patient Experience*, which examined whether FFS Medicare beneficiaries affiliated with Pioneer ACOs, which share both risk and revenue, spent less than other FFS Medicare beneficiaries. Overall, the researchers found that beneficiaries associated with Pioneer ACOs had lower increases in expenditures than those in traditional FFS (-$280M in 2012, and -$105M in 2013), with little difference in the patient experience. In the May 19th issue, Ateev Mehrotra and Peter

Hussey questioned, *Including Physicians in Hospital Bundled Care Payments: Time to Revisit an Old Idea?*. This Viewpoint piece explores the benefits and challenges to including physicians in Medicare's bundled hospital payment system, and argues that substantial benefits in terms of administrative costs, increased physician engagement in quality improvement efforts, and reduce time spent on documentation.

The General Accounting Office also addressed physician payments in its report – *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*. In this study, the GAO evaluated the process used by the Relative Value Scale Update Committee (RUC), responsible for updating the Relative Value Scales used to pay Medicare physicians, in both recommending relative values for CMS consideration and establishing relative values. The GAO recommended that the RUC should better document its process in establishing relative values and develop a plan for informing the public about mis-valued services.

In the private market, some hospital systems are responding to changes in payment by launching their own health insurance plans, according to Joanne Finnegan. In her Special Report in Fierce Healthcare, Hospitals as Insurers: Competition, costs, and considerations, Finnegan talked to leaders from UPMC, MedStar Health and North Shore-LIJ Health System about their plans to get into the insurance game. She particularly notes the potential revenue opportunities as well as the possibilities for improvements in population health.

Others may look to reducing overhead costs to save money. Noah Kalman, Bradley Hammill, Kevin Schulman and Bimal Shah examined *Hospital Overhead Costs: The Neglected Driver of Health Care Spending?* in the Journal of Health Finance. The authors found that hospital overhead costs accounted for 46.1% of total hospital costs between 1996 and 2010, and that mean hospital overhead costs per inpatient bed and per inpatient day increased faster than medical inflation!

Finally, still others may look to find partners to affiliate with to ease the transition to value based payments. In *A Good Merger* published in the May 28th issue of the New England Journal of Medicine, Leemore Dafny and Thomas Lee outline the characteristics of what makes a merger pro-competitive and efficient, as opposed to anticompetitive. While Dafny and Thomas note that the "most consistently documented result of provider mergers is higher prices" and improved value and efficiency has rarely been achieved, they do offer a nice table of potential efficiencies that could arise from a merger to help organizations consider whether any particular merger could buck the trend and have positive results.

That's it for May! We hope this Roundup lets you get out and enjoy the nice weather a little bit sooner!