Academic Articles & Reports Round-Up: November 2015

We hope you all had a great Thanksgiving, full of friends, family, and cheer! November yielded some interesting articles and perspectives on health care markets and consolidation, price transparency, payment reform, prescription drug pricing, more ACA litigation, and health care spending. Enjoy!

HEALTH CARE MARKETS/CONSOLIDATION

Multiple articles discussed the effects of health care markets and consolidation on various health care entities. Early in November, the Alliance for Health Reform published an article entitled *Health Care Consolidation*. The article uses numbers and statistics to paint a vivid picture of the increase in health care mergers and acquisitions in 2014. The article states that, in 2014, there were 1,299 health care mergers and acquisitions, valued at $387 billion—both record highs. The article shows that health care mergers and acquisitions increased 26% from 2013, and the value of the deals increased by 137%. The authors conclude that, in 2014, health care consolidation was mostly attributed to pharmaceutical companies (whose mergers and acquisitions increased) and not due to providers and hospitals (whose number of mergers and acquisitions decreased). The article ended by mentioning that the "Big 5" health care insurance companies hold 83% of the national market share, but did not state how insurance mergers and acquisitions affected overall health care consolidation in 2014.

Later in November, the Commonwealth Fund published an article entitled *Evaluating the Impact of Health Insurance Consolidation: Learning from Experience*. The article's author, Professor Leemore Dafny, reports that research has shown that private health insurance consolidation leads to premium

increases for consumers. Professor Dafny argues that insurer transparency on enrollment, premiums, and costs of commercial health insurance will be pivotal in helping market experts decide who benefits and who is harmed by insurer consolidation.

The Journal of Business Logistics published an article on hospital supply chains in an article entitled *The Emergence of Consolidated Service Centers in Health Care*. The article details the complexities and difficulty inherent in optimizing and managing hospital supply chains. The article further argues that consolidated service centers ("CSCs") show a strong potential for reducing hospital supply chain complexity and increasing performance and innovation.

And finally, the Delft University of Technology published an article entitled *Is Healthcare a Market? Does turning health care into a market lower the cost (and increase the quality) of health care?* The article analyzes neoclassical markets and explains why health care is a distinct market that does not fit into the neoclassical model. The author urges policy makers to take into account other health care considerations when asserting new policy initiatives: the purpose of health care and, in addition to health, alternative motives underpinning the allocation of health care resources.

PAYMENT REFORM

Payment reform was also heavily discussed in November. The Journal of the American Board of Family Medicine published an article on *Direct Primary Care: Practice Distribution and Cost Across the Nation*. The article examines the use of direct primary care ("DPC")—an alternative to third-party fee-for-service billing that charges patients a periodic fee for primary care services. The article concludes that DPC practices are broadly distributed throughout the United States and are associated with lower price points, but the data on DPC quality is lacking.

Then, Health Services Research published an article on *The Theory of Value-Based Payment Incentives and Their Application to Health Care*. The authors analyzed research and empirical literature on value-based payments and found that, in order to improve patient experience, clinical quality, health outcomes, and the creation of achievable benchmarks for improved outcomes, value-based payments should be coupled with quality and efficacy incentives for providers. The authors conclude that one of the best ways to create provider incentives is through payment contracts that are "incentive compatible."

Lastly, Health Affairs published an article on *Bundled Payments for Care Improvement Initiative* that describes the various new Medicare payment models being tested, by CMS, under the Bundled Payments for Care Improvement ("BPCI") initiative. This article offers a comprehensive analysis on the types of BPCI being tested and the pros, cons, and implications of each.

PRICE TRANSPARENCY

Multiple entities discussed price transparency in November, and each from a different perspective. First, the Journal of Health Care for the Poor and Underserved published an article entitled *Attaining Financial Fluency among Physicians: Start with the Students* that urges the medical field to teach physicians, early in their careers, to discuss health care prices and costs with patients. The authors argue that the ideal setting for this type of training is student-run community clinics where volunteer physicians treat low-income, uninsured patients and the medical student trainees coordinate patients' care. This setting, the authors argue, will train physicians to "expect, rather than fear" cost of care discussions, which will subsequently increase price transparency and patient adherence to medical care.

Next, the Annals of Otology, Rhinology &amp|Laryngology journal posted an article on *Surgeon Awareness of Operating*

Supply Costs. The article concludes that the majority of surgeons polled in the small sample study could not estimate the costs of items/implants used in the operating room. The authors deduced from these findings that an opportunity exists to improve cost data to physicians in order to promote value-based decision-making. Although the study was small, the results seem to align with the general consensus on price transparency: physicians and patients benefit from knowing the price of health care services and items.

Finally, the New England Journal of Medicine published an article entitled *Transparency and the Supreme Court—Can Employers Refuse to Disclose How Much They Pay for Health Care?* The article's authors explain the basis for the *Gobeille v. Liberty Mutual* case that "threatens to cripple [all-payer claims] databases and other state initiatives that aim to improve the health care system." The issue at the heart of *Gobeille* is whether the Second Circuit erred in holding that ERISA pre-empts Vermont's all-payer claims database law as applied to a third-party administrator of a self-funded ERISA plan. The NEJM article authors think that Liberty Mutual has a weak argument, but they explain the case's potentially far-reaching implications on price transparency should the Supreme Court side with Liberty Mutual. The Supreme Court is set to hear arguments on this case on December 2, 2015. If reading about this Supreme Court case piques your interest in APCDs, you will also want to read The New England Journal of Medicine's *Maryland's Global Hospital Budgets—Preliminary Results from an All-Payer Model* discussing the state's all-payer model.

PRESCRIPTION DRUGS

The New England Journal of Medicine published an article on *Measuring the Value of Prescription Drugs*. The article argues that the move toward value-based frameworks for assessing drugs is a "positive step," while also acknowledging that value is an "elusive target." Furthermore, the article

explains why new initiatives to set drug prices to reflect research, development, and production are misguided since they do not focus on a drug's value. The article also discusses the potential for private-sector solutions to control drug prices and the potential for various scoring initiatives to provide drugs with a physical score that could then be used to compare various drugs. The article also discusses the difficulty inherent in assessing drug "affordability" and budget impacts. Lastly, the article discusses the effect cost-setting and low-value interventions could have on every medical industry stakeholder. Using the "effective but expensive hepatitis C drug," Sovaldi, as an example, the authors conclude that the United States needs a drug value assessment measure and that current strategies require immense refinement but are ultimately a step in the right direction.

MORE ACA LITIGATION

The New England Journal of Medicine published an article entitled *The House and the ACA—A Lawsuit over Cost-Sharing Reductions*. In this article, Timothy Stoltzfus Jost, J.D., discusses how the ACA has already, in its short life, "twice survived a near-death experience at the hands of the judiciary" and is under attack again in *House v. Burwell*. Professor Jost states that the issue in *House v. Burwell* is whether funding for cost-sharing reductions has been properly appropriated but believes that the "really significant" issue in the case is whether the House can even bring the case. Professor Jost argues that, in the past, federal courts have refused to interject themselves into disputes between Congress and the executive branch. Judge Collyer, of the U.S. District Court for the District of Columbia, however, has "chosen to enter the fray," and in Professor Jost's opinion, will likely be "ultimately reversed upon appeal" and will "in the interim[,] cause uncertainty for insurers, consumers, and providers."

HEALTH CARE SPENDING

The BMJ published a very interesting article on provider resource use and its relationship to malpractice claims in an article entitled *Physician spending and subsequent risk of malpractice claims: observational study*. In it, the authors studied whether a higher use of resources by physicians was associated with a reduced risk of malpractice claims. They studied nearly all of the acute care hospital admissions, in Florida, in 2009-10, that were linked to the attending physician's malpractice history. The authors then adjusted the data for patient characteristics, comorbidities, and diagnoses and used the data to predict if the physician was less likely to face malpractice allegations the following year. The authors concluded that, within a physician's specialty, and after patient characteristic adjustment, physicians with higher resource use were associated with fewer malpractice claims. The authors do admit, however, that their study was limited by a lack of illness severity, as well as uncertainty as to whether higher spending was defensively motivated by previous malpractice claims against the physician.

Happy Holidays! See you next month!