September Articles and Reports Roundup

With the end of summer and school in full swing, September brought us a wide range of interesting articles and reports. This month, the Roundup will highlight seven articles and one report on a range of topics, but there were many to choose from, so check out The Source –Perspectives-Articles and Reports to see what else we picked up!

Narrow Networks

Jonathan Gruber and Robin McKnight posted an NBER Working Paper, *Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees*, which examines the growing trend of narrow networks as a means to control healthcare costs. Massachusetts GIC, the insurance plan for state employees, recently introduced a major financial incentive to choose limited network plans for one group of enrollees and not another. Employees proved very price sensitive in their decisions to enroll in limited network plans and spending fell by nearly 40% for those enrolled in the plan. Interestingly, savings came entirely from reductions in spending for specialists, rather than primary care. Further, the researchers found that savings only occurred when patients' primary care doctors were in the narrow network, suggesting that broader primary care networks are advantageous.

Pioneer ACOs

Hoangmai Pham, Melissa Cohen, and Patrick Conway published *The Pioneer Accountable Care Organization Model: Improving Quality and Lowering Costs* in JAMA Online First on September 17th. The article examines the first two "performance" years for the Pioneer ACOs and their relationship with CMS. In aggregate, Pioneer ACOs improved their performance in all areas of the triple aim – higher quality, better patient experience, and lower spending. Pioneer ACOs had

mean quality scores of 84% in 2013, up from 70.8% in 2012, and the average shared savings increased from $2.7M to $4.2 M. The article also considers the goals Pioneer ACOs strive to attain in 2014. While noting these positive aspects of the ACOs that stayed in the program, numerous Pioneer ACOs have dropped from the program since its inception, suggesting that making these changes is tougher than expected.

Relative Value Health Insurance

Ari Friedman and Siyabonga Ndwandwe published a brief comment on Health Affairs blog, *Relative Value Health Insurance and Pay for Performance for Insurers: Complements, Not Substitutes*, that discusses the benefits and detriments of relative value health insurance (RVHI) and Payment for Performance for Insurers (P4P4I). RVHI proposals would entail the government ranking health insurance plans not by the percentage of the total cost that they cover, but instead by their relative cost effectiveness, such that insurers could deny coverage for services that are very expensive in relation to the overall health benefit received. By comparison, P4P4I focuses on incentivizing procedures that benefit patient health. The authors examine the benefits and drawbacks of both RVHI and P4P4I in some detail. The post also covers some basic concepts of health economics, which provides a good primer for this debate. The authors argue in the end that the most politically and practically feasible option combines the approaches to create incentives for positive patient outcomes alongside strong incentives for cost-effectiveness.

Price Transparency

In the September 1st issue of the Annals of Surgery, Kate Russell *et al.*, published *Charge Awareness Affects Treatment Choice: Prospective Randomized Trial in Pediatric Appendectomy*, which documents much needed evidence that patients will respond to price information in medical decision-making under certain circumstances. The study examined the impact on patient decision making when cost information was provided for two procedures, laproscopic and open appendectomies, which are in clinical equipoise (they have similar outcomes).

Although medically laproscopic and open appendectomies have similar outcomes, open appendectomies cost significantly less. Russell *et al.* randomized patients into a price disclosure group and a non-price disclosure group. In the price disclosure group, patients were 1.8 times more likely to choose an open appendectomy than in the non-price disclosure group. The median savings per patient in the price disclosure group was $528, and 90% of patients said they valued having pricing information. This kind of study is very useful to understanding under what circumstances price transparency can promote cost savings and benefit patient decision-making.

Administrative Costs

The September issue of Health Affairs had a number of interesting articles (as always), but this one really caught our eye. David Himmelstein *et al.*, published *A Comparison of Hospital Administrative Costs in Eight Nations: US Exceeds Others By Far*. While this is not exactly news to those following U.S. healthcare closely, the amount of savings available by changing the administrative structure of hospitals is quite substantial. The group assembled a team of international health policy experts to examine hospital administrative costs in Canada, England, Scotland, Wales, France, Germany, the Netherlands, and the United States. In the United States, administrative costs accounted for 25.3% of hospital expenditures, compared with 19.8% in the Netherlands, 15.5% in England (both of which are transitioning to market systems), and 11.6% in Scotland and 12.4 in Canada (single payer systems). The authors estimate that the United States could have saved $150B in 2011 if our administrative costs mirrored those of Scotland. The article analyzes a number of reasons for our high administrative spending, and recommends some payment strategies to minimize administrative overhead.

Vertical Integration

For those of you who like to get the latest of the latest, Thomas Koch, Brett Wendling, and Nathan Wilson, posted a work in progress piece titled *How Vertical*

Integration Affects Total Health Outcomes and Total Costs for Medicare Recipients. This article explores the impact of vertical integration via hospital acquisition of physician groups. Vertical integration is a growing trend and much debate exists over whether it will promote cost saving efficiencies or further consolidate markets, driving up costs, is largely unknown. Take a look at this preliminary draft for some insight into this trend.

Quality, Cost and Competition

Another hot-off-the-press work-in-progress is from health services researchers at Dartmouth, Carrie Colla, Julie Bynum, Andrea Austin, and Jonathan Skinner, titled Hospital Competition, Quality, and Expenditures in the U.S. Medicare Population. This very interesting article examines the oft-cited theoretical model that competition in fixed price markets (like Medicare) will cause hospitals to compete on quality for disease with the greatest profitability and demand elasticity. The authors move beyond prior evidence looking at heart attack patients (high profitability, but low demand elasticity, because heart attack patients are taken to the nearest hospital versus the highest quality) to also examine how the model works on knee and hip replacement patients (high profitability and high demand elasticity) and dementia patients (low or negative profitability). The study replicated the finding that greater competition leads to higher quality in heart attack patients, but found no evidence for competition improving quality for knee and hip replacements, which should theoretically be the most competitive markets. In fact, in dementia care, more competition was found to be associated with lower quality care, such that greater competition discourages hospitals from taking unprofitable patients. Both findings are inconsistent with the theory, and reflect the ways that the healthcare market deviates from standard economic theory. Also of note, the authors use the logit competition index (LOCI) approach to estimate competition, rather than the Herfindahl-Hirschman Index (HHI), which may support a growing trend toward moving away from HHI in healthcare cases.

Rate Review

Our last highlight from September is HHS's 2013 Rate Review Report. The ACA requires any insurer requesting a rate increase of over 10% to submit the increase for review to HHS and any relevant state agency overseeing insurance in the state. The Rate Review program began in 2011. This Report examines data from 40 states in the individual market and 37 states in the small group market to estimate the impact of the Rate Review Program. Key findings of the 2013 report include: 1) rate review reduced total premiums by an estimated $290M in the individual market in all states; 2) in the individual market, the average requested rate was reduced by 8% for the 40 states; 3) rate review reduced total premiums by $703M in the small group market for all states; and 4) in the small group market, the average rate requested was reduced by 11%.

That's it for September! Look for us again on Halloween!