

The Source Roundup: August 2018 Edition

Happy August! In this edition of the Source Roundup, we cover four academic articles and reports from June and July. The topics this month include: (1) price transparency as a means to affordable health care; (2) effect of state-based individual mandates; (3) Trump's 5-Part Medicare Part D plan; and (4) Medicare's experiment with bundled payments.

Price Transparency Goals to Achieve Affordable Health Care

Skeptics have questioned whether consumer price transparency initiatives are an effective means of driving down healthcare costs. In the NEJM Catalyst article, [“Defining the Goals of Health Care Price Transparency: Not Just Shopping Around,”](#) Ateev Mehrotra, David Schleifer, Amy Shefrin, and Andrea M. Ducas set out four different price transparency goals that each address a different purpose and audience to measure whether price transparency actually “works.” The first goal is to arm patients with knowledge of the cost of healthcare (particularly out-of-pocket costs) so they can avoid sticker shock from medical services. The biggest roadblock that prevents this goal from being accomplished is that Americans do not know where to look for healthcare pricing information. Moreover, even when they have knowledge of healthcare prices, they still are unable to contextualize how to use that information to find the most affordable medical service. In order to minimize a patient's post-medical care sticker shock, providers and insurers must be just as involved as patients in price transparency efforts and provide the necessary data to patients regarding out-of-pocket costs. The second goal is to reveal to the public the total reimbursement from the insurer and patient, also known as the total provider price. By exerting pressure on high-priced providers to rein in their exorbitant medical care prices, it could eliminate high-priced outliers from networks and slow down the growth of average healthcare prices. The third goal is to increase price shopping so patients can compare out-of-pocket prices and choose a lower-priced provider to receive care. The authors found that only 20 percent of Americans have

participated in price shopping, but this number can be increased if price transparency tools were made more user-friendly and accessible. The final goal of health care price transparency is to enable providers with the tools to have productive conversations with their patients about affordable care options. Besides creating provider-facing price transparency tools, the authors theorize it would require legislative action to give providers the ability to determine their patients' out-of-pocket costs across different providers, not just their own. Overall, price transparency is just a method to achieve the overarching goal of making healthcare affordable.

Implications of Enacting State-Based Individual Mandates

In the Commonwealth Fund article, "[How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs](#)," Linda J. Blumberg, Matthew Buettgens, and John Holahan examine how state-specific individual mandates could mitigate the effects of the elimination of the individual mandate's financial penalty under the Affordable Care Act ("ACA"), effective 2019. This analysis is based on the Urban Institute's Health Insurance Policy Simulation Model, which estimates the cost and coverage effects of hypothetical health care policy options. The Congressional Budget Office estimates there will be an additional 3 million uninsured in 2019, which would cause premiums in nongroup insurance market to increase by 15 percent. However, the authors find that if each state were to enact individual mandates, the number of uninsured would decrease by 3.9 million people by 2019, and 7.5 million by 2022. Additionally, marketplace premiums would decrease by an average of 11.8 percent. However, the actual impact of state individual mandates would vary across states depending on the state's existing ACA enrollment of healthy individuals, who had enrolled only because of the federal individual mandate. For example, premiums in New Mexico would experience a decrease of 21.1 percent if the state implemented the individual mandate, whereas Minnesota would only experience a 10 percent decrease because of its current Basic Health Program. The authors note that some states, such as Massachusetts and New Jersey, have already enacted their own individual mandates. For other states, however, obstacles lie ahead. In particular, states with no state income taxes will

experience difficulty in designing the structure for collecting the individual mandate penalty. This analysis assumes that state-specific individual mandates would be designed similarly to the federal individual mandate and adopted nationally; however, the authors suggest such a widespread enactment is unlikely to occur based on the different political stance states holds with respect to the ACA.

Breaking Down the Trump Administration's 5-Part Proposed Plan for Medicare Part D

In the Kaiser Family Foundation issue brief "[What's in the Administration's 5-Part Plan for Medicare Part D and What Would it Mean for Beneficiaries and Program Savings](#)," Juliette Cubanski dives into the Trump Administration's blueprint on drug costs under Medicare Part D and how it could affect beneficiaries. The first feature of the 5-part plan requires Part D plans to share at least one-third of rebates with enrollees at the point of sale in order to lower out-of-pocket costs for specific medications; however, the author notes that it could also increase premiums for all enrollees because costs would not be covered by the entire value of negotiated rebates with drug manufacturers. Second, the Administration suggests changing the calculation of an enrollee's "true out-of-pocket spending" ("TrOOP") by excluding the manufacturer's price discount for brand-name drugs filled during a beneficiary's coverage gap. Cubanski contends that while modifying the TrOOP calculation would shift the out-of-pocket cost burden from coverage gap to the enrollees, it could ultimately result in lower plan costs and premiums because enrollees would be incentivized to progress to the catastrophic coverage level more slowly. Part 3 of the plan proposes a 3-prong attack to reduce catastrophic coverage phase out-of-pocket costs by: (1) creating an out-of-pocket limit to Part D and removing cost sharing requirements currently imposed on beneficiaries during the phase; (2) increasing the plans' share of an enrollee's total cost from 15 percent to 80 percent; and (3) decreasing Medicare's cost share from 80 percent to 20 percent. In Part 4, the Administration seeks to empower plans during pharmaceutical price negotiations by relaxing the plan formulary requirement from at least two drugs per drug category to one drug. Cubanski suggests this could result in lower premiums as plans are able to negotiate larger discounts over covered drugs and apply greater utilization

management restrictions to specialty drugs and drugs in protected classes. Finally, Part 5 of the plan proposes eliminating cost sharing on generic drugs for low-income enrollees, which would encourage the use of generics and in turn, reduce out-of-pocket costs. Ultimately, as discussed in the brief, the 5-part plan attempts to impose financial incentives on both enrollees and plans by targeting out-of-pocket costs, premiums, and access to medications.

Examining the Results of Medicare Bundled Payments

In the New England Journal of Medicine article "[Evaluation of Medicare's Bundled Payments Initiative for Medical Conditions](#)," Karen E. Joynt Maddox, E. John Orav, Jie Zheng, and Arnold M. Epstein analyze how successful the relatively new Medicare Bundled Payments for Care Improvement (BPCI) initiative has been in reducing costs for the treatment of certain medical conditions. In contrast to the traditional piecemeal medical service billing system, Medicare has been experimenting with bundled payments, in which Medicare pays for a patient's entire "episode of care." Medicare was inspired to study how BPCI could lower costs for specific medical conditions due to the success of BPCI for joint replacements. However, the authors conclude that over the 3 year study, there was no significant reduction in Medicare payments for average length of hospital stay, care provided, and emergency department use, nor improved quality for hospitals that participated in BPCI. The BPCI results for joint replacements and medical conditions may have differed due to the difference in average age and rates of poverty and disability of patients who required joint replacements as compared to those with medical conditions. Additionally, the authors suggest the type of care postacute care facilities provided to patients may have adversely affected the final results, but quality of care could improve in the future if hospitals developed stronger partnerships with postacute care providers. Although the BCPI outcomes were not as successful as one would like, the authors believe lower healthcare costs and higher quality of care could still be achieved with more time and additional incentives.

That's all for this month's Roundup. 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