The Source Roundup: December 2023 Edition

Healthcare Prices and Cost

- **In An Era Of Premium And Provider Price Increases, State Employee Health Plans Target Key Cost Drivers** (***Health Affairs Forefront***)

Sabrina Corlette, Karen Davenport

Employer-sponsored health insurance premiums have outpaced inflation and are poised for significant rate hikes this year. State Employee Health Plans have been in a prime position to address health care costs. Administrators of these plans identified reference pricing, tiered network plans, and multi-payer purchasing initiatives as having promising results in addressing cost drivers.

- **The Joint Distribution Of High Out-Of-Pocket Burdens, Medical Debt, And Financial Barriers To Needed Care** ***(Health Affairs)***

Didem M. Bernard, Thomas M. Selden, and Zhengyi Fang

Where prior research has focused on aspects of healthcare financial pressures separately, the authors believe a more complete picture of the challenges faced by US families can be obtained by examining the joint interaction of high out-of-pocket spending, long-term medical debt, and delays (or

avoidance) in needed care due to costs. The analysis of the wide distribution of financial strain across sociodemographic characteristics, families' health care needs, insurance coverage, and financial resources provides insight for ongoing reforms in billing, coverage, and medical debt, as well as highlighting the importance for health care financing reform.

Price Transparency

- **Hospital Pricing Information Consistent Between Transparency-In-Coverage Data And Other Commercial Data Sources** ***(Health Affairs)***

  Yang Wang, Mark Meiselbach, Gerard F. Anderson, Ge Bai

  Commercial in-network facility prices for five common shoppable hospital procedures disclosed under the Transparency in Coverage (TiC) rule are compared with commercial prices from two data sources that have been widely used in prior hospital pricing research. The goal of the authors is to determine whether prices disclosed in TiC data sets are comparable to prices disclosed in other national data sets. They found that the TiC pricing data are at least as reliable as the hospital-disclosed and Marketscan data for producing nationwide pricing patterns. This finding is important for stakeholders interested in using TiC data for general inferences.

Pharmaceutical Costs and Competition

- **Pharmacy Benefit Managers History, Business Practices, Economics, and Policy** *(JAMA Health Forum)*

T. Joseph Mattingly II, PharmD, MBA, PhD; David A. Hyman, MD, JD; Ge Bai, PhD, CPA

Pharmacy benefit managers (PBMs) play a major role in the provision of pharmacy services by acting as intermediaries between pharmacies, plan sponsors, pharmaceutical manufacturers, and drug wholesalers. This work reviews historical events; previous and current industry practices and publications; prior academic literature, existing statutes, regulations, and court cases; and recent legislative reforms and agency actions regarding PBMs to provide an overview of the PBM industry, including an assessment of the current policy landscape and an analysis of how proposed policies could affect PBM practices and patient care.

- **Confronting High Costs And Clinical Uncertainty: Innovative Payment Models For Gene Therapies** *(Health Affairs)*

Caroline Horrow and Aaron S. Kesselheim

Gene therapies offer potentially life-changing benefits for patients, but their unprecedented high prices exacerbate challenges for reimbursement by payers. Alternative payment models may address reimbursement problems and ensure equitable patient access. Possible payment models take three main approaches: amortization, risk spreading, and performance-based payment. The advantages and challenges of each model are examined, as well as considerations for

payers.

Private Equity and Healthcare Financing

- **Private Equity Promised to Revolutionize Health Care. Is It Making Things Worse?** ***(The Commonwealth Fund – The Dose podcast)***

The multi-trillion-dollar industry of health care in the U.S. has become an attractive venue for private investors, who promise cost savings, expanded use of technology, and streamlined operations, in exchange for profit. The growing role of private equity in American health care is, on the whole, failing to live up to its promises – and may actually be deepening inequality.

- **To Profit Or Not? Lessons From The Insurance Front Lines** ***(Health Affairs)***

Paula A. Steiner

A former Blue insurance plan executive reflects on why neither for-profit nor not-for-profit financing has delivered what we want in health care. Steiner asserts that focusing on how the profit motive influences costs, access, and innovation distracts from the more important confrontation: the price we are willing to pay when we are healthy versus the services we expect when we are sick. Steiner believes that the disregard for this conflict has been a barrier to achieving the goal of a more humane health system for all.

- **Private Equity's Role in Health Care** ***(The Commonwealth Fund)***

David Blumenthal

Private equity's role in health care is rapidly growing, particularly through acquisitions of high-margin specialist practices, raising concerns over the impact of private equity ownership on health care costs, equity, and access. The author examines steps policymakers could consider, including new transparency rules and reforming antitrust laws, to open the sale of local physician practices to scrutiny.

Health Insurance Coverage Trends

- **Medicaid Enrollment and Spending Growth Amid the Unwinding of the Continuous Enrollment Provision: FY 2023 & 2024** ***(Kaiser Family Foundation)***

Elizabeth Williams, Elizabeth Hinton, Robin Rudowitz, and Anna Mudumala

Medicaid enrollment and spending trends for FY 2023 and FY 2024 are analyzed based on data provided by state Medicaid directors to determine how the unwinding of the Medicaid continuous enrollment provision (due to the end of the federal public health emergency in 2023) and the phase-down of the enhanced Federal Medical Assistance Percentage (FMAP) will affect Medicaid spending and enrollment in the states.

- **California Achieves Lowest Uninsured Rate Ever**

in 2022 ***(California Health Care Foundation)***

Lacey Hartman

The share of Californians under age 65 without health insurance reached a historic low in 2022 and disparities in coverage by race and ethnicity have narrowed. As the federal continuous coverage requirement for Medicaid ended in 2023, maintaining coverage gains will hinge on transitioning people who lose Medi-Cal to other forms of coverage in coming months.

- **California Health Insurance Enrollment in 2022: Medi-Cal Growth Drives Overall Enrollment to Record High** ***(California Health Care Foundation)***

Katherine Wilson

Total health insurance enrollment in California increased by 1.6 million in 2022 to a record total of 35.9 million enrollees, with Medi-Cal managed care as the largest driver of the gains. The unwinding of Medi-Cal continuous enrollment policies is expected to result in two to three million enrollees leaving Medi-Cal. Where these individuals will transition to is unknown, so it is important to closely monitor enrollment levels among different coverage sources as well as the uninsured rate in 2023 and 2024.

Public Health Insurance Policy

- **Merging Rural And Urban ACA Rating Areas Improved Choice, Premiums In Rural Texas**

(Health Affairs)

Simon F. Haeder, Elena Andreyeva, Daniel Marthey, and Benjamin D. Ukert

To address the issues that rural healthcare consumers face (i.e., limited choice of carriers and plans and high premiums), Texas recently adjusted its Affordable Care Act Marketplace rating areas to integrate rural areas into nearby urban markets for rating purposes. The authors determine that this resulted in rural consumers seeing increases in carrier and plan choices, as well as decreases in overall plan premiums.

- **CBO Report Highlights Need For Change Of Direction In Health Policy** *(Health Affairs)*

Brian C. Blase

The Congressional Budget Office (CBO) released its annual report on federal subsidies for health insurance, which included Medicare for the first time. The CBO's report shows the tremendous growth of federal health spending and that 99 percent of Americans have insurance coverage or an opportunity to obtain subsidized coverage, highlighting the need for policy makers to focus on lowering costs and reforming government programs and policies that push up prices and spending.

- **Policy Innovations in the Affordable Care Act Marketplaces** *(The Commonwealth Fund)*

Rachel Schwab, Rachel Swindle, Jalisa Clark, Justin Giovannelli

With enrollment in the ACA marketplaces at a record high and expected to grow further, many states are experimenting with ways to make shopping for the right health care coverage easier and more efficient for consumers. State insurance marketplaces have pursued innovations that help consumers navigate their plan options, reduce administrative burdens, require or incentivize insurer participation, and address disparities in coverage and care. The article observes that some policies that hold promise for improving coverage access have yet to be adopted broadly, and wide variation across states suggests a need for nationwide implementation of some of the policies identified.

- **Legislative and Regulatory Options for Improving Medicare Advantage** ***(Journal of Health Politics, Policy and Law)***

Erin C. Fuse Brown, Travis C. Williams, Roslyn C. Murray, David J. Meyers, Andrew M. Ryan

Many argue that Medicare Advantage is failing to deliver on its promise to reduce spending. An analysis of the statute underlying the problematic design features leads to the conclusion that regulatory approaches for improving risk adjustment and for recouping overpayments from risk-score gaming have the highest potential impact and are the most feasible improvement measures to implement.

Provider Network and Directory

Adequacy

- **State Efforts to Regulate Provider Networks and Directories: Lessons for the Future** ***(Journal of Health Politics, Policy and Law)***

Simon F. Haeder, Wendy Y. Xu, Thomas Elton, IV, Ariana Pitcher

After the managed care backlash, governments moved to ensure consumer access by issuing a number of requirements for carriers related to the composition and size of their networks and how this information is shared with consumers. The authors provide a comprehensive review of these state-based efforts to regulate provider network adequacy and provider directory accuracy for commercial insurance markets. In addition to common measures of adequacy, they also include requirements specifically targeted to underserved populations. This is especially relevant as other work has raised significant questions about whether these efforts are effective, particularly considering the limited nature of enforcement. They also provide a brief overview and assessment of recent federal government efforts that replicate these state regulations with a focus on lessons learned from state regulations that may help improve their federal counterparts. A future research agenda focused on a more comprehensive evaluation of efforts to ensure consumer access is outlined.