

The Source Roundup: July 2018 Edition

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Happy July! In this edition of the Source Roundup, we cover six academic articles and reports from May and June. The topics this month include: (1) the drug rebate system, (2) provider-payer integration as model for healthcare reform, (3) anticompetitive behaviors that delay generic drug competition, (4) short-term insurance plan expansion increases 2019 ACA marketplace premiums, and (5) competition concerns of healthcare consolidation.

The Drug Rebate System is Not the Villain in Rising Health Care Costs

There are plenty of reasons health care price inflation continues to affect the United States, but the drug rebate system is not the problem. At least that's what Anthony T. Lo Sasso and Ike Brannon argue in the SSRN article, [Drug Rebates Do Not Increase Costs to Consumers](#). Rather than driving up healthcare costs, the authors contend that drug rebates help maximize social welfare by expanding the scope of patients that can be accommodated. Additionally, Sasso and Brannon believe that it may not be the rebates that are objectionable to most people, but rather the lack of transparency regarding their nature and amount. While these are valid concerns, there are also legitimate business reasons for this lack of transparency, especially because the outcome of negotiations is considered trade secret. Rebates, the authors believe, are part of a negotiation process between pharmacy benefit managers and

manufactures that “injects a modicum of market discipline.” Sasso and Brannon warn that a world without rebates is a world with higher premiums for insurance and drugs, and would lead to a more convoluted system that would allow drug companies to make higher profits without doing anything to earn them.

Provider-Payer Integration Helps Improve Quality and Reduce Costs

In the NEJM Catalyst article [Effective Consolidation: A Model for Reform Through Payer-Provider Integration](#), authors William H. Shrank, Diane Holder, and Steven Shapiro take an in-depth look at the unique experiment in Western Pennsylvania as a potential model for reform. Western Pennsylvania was one of the nation’s least competitive health care environments where one insurer controlled around 65% of the market. In 1997, the University of Pittsburgh Medical Center (UPMC) launched its own health plan under the integrated delivery and finance systems (IDFS), which join providers and payers in the transition from volume to value. These systems help create more competition in the health care market which in turn helps improve health care. IDFSs differ from independent hospitals and insurers in that they are accountable for both the quality of care provided to patients and the cost of coverage purchased by consumers. The payer-provider model focused on reducing low-value treatment, shifting services to appropriate lower-cost settings, managing and preventing chronic disease, and establishing more coordinated models of care. By 2010, Pittsburgh was identified as one of only 16 U.S. cities providing high hospital value for both Medicare and commercially insured patients. UPMC is now one of the largest and fastest growing provider-owned health plans in the nation. Given the success of this model, the authors urge policymakers and the Centers for Medicare and

Medicaid Services to focus on marketplace structure to help reduce health care costs.

Brand-Name Drugmakers' Anticompetitive Behaviors Delay Generic Competition

The Commonwealth Fund article, [Anticompetitive Efforts to Block Affordable Drugs: A Patient's Story and Policy Solutions](#), by Henry Waxman, Bill Corr, Kristi Martin, and Sophia Doun, follows a patient's true story to illustrate how anticompetitive practices that delay generic drugs from entering the market affect patients. The article discusses different ways that brand-name drug manufacturers prevent or delay generics from entering the market. First, a brand manufacturer may prevent a generic from accessing samples or bioequivalence testing by manipulating the required Risk Evaluation and Mitigation Strategy (REMS) program. Second, if a brand-name drug is subject to an FDA-mandated REMS program, then the generic manufacturer must share the same REMS program, which is done through a negotiation process. The brand manufacturer can delay the establishment of a shared REMS program by prolonging negotiations.

The authors look at how the Trump administration and Congress have tried to address these anticompetitive behaviors. As part of the efforts to lower prescription drug prices, President Trump called out REMS abuse and solicited public comment to address them. The FDA has also issued two draft guidances to address REMS abuse. The authors propose that the FDA establish stricter criteria to ensure that brand-name manufacturers provide samples to generic manufacturers within an appropriate time or for Congress to expand FDA's authority to impose civil monetary penalties on manufacturers that abuse the REMS programs

in order to lower prices and increase access to medication for patients.

Short-Term Insurance Plan Expansion May Increase Premium on the Individual Market

In February 2018, the U.S. Departments of Treasury, Labor, and Health and Human Services proposed a rule that would expand health insurers' ability to sell short-term limited duration (STLD) health plans. Currently, short-term plans may only be sold for three-month terms. The new rule proposes that insurers be allowed to sell short-term plans for terms of up to 12 months. The Commonwealth Fund report, [What is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans is Increased](#), by Preethi Rao, Sarah Nowak, and Christine Eibner, analyzes the effects of short-term health insurance policy changes on health insurance enrollment and premiums. The authors used the RAND COMPARE microsimulation model to analyze the impact of extending short-term plans as a standalone policy and in combination with individual mandate repeal. The authors point out that STLD plans aren't new, but their enrollment has historically been low. One reason for low enrollment could be that those who had short-term plans were subject to the Affordable Care Act (ACA) individual mandate penalty unless they had another source of coverage. However, by passing the Tax Cut and Jobs Act in 2017, Congress repealed the ACA's individual mandate penalty, which the authors believe would lead to increased enrollment in non-compliant STLD plans. Also, because short-term plans are less comprehensive and usually cheaper than ACA-complaint policies, they generally attract young, healthy people who do not expect to need insurance. The authors hypothesize the switch of healthier individuals to STLD plans would increase premiums for plans

purchased on the individual market.

2019 ACA Marketplace Premiums Increase

In [Tracking 2019 Premium Changes on ACA Exchanges](#), published by the Kaiser Family Foundation (KFF), Rabah Kamal et al. update the review of preliminary premium rates as data become available for states. Each year, insurers must submit filings to state regulators detailing their plans to participate in the ACA marketplaces. The information must include the premiums insurers plan to charge in the coming year and which areas they plan to serve. The state or federal government reviews the proposed premiums to ensure they are justifiable before the rate goes into effect. The analysis looks at the lowest-cost bronze, second lowest-cost silver, and lowest-cost gold premiums in all states and the District of Columbia. The second lowest-cost silver plan serves as the benchmark for premium tax credits and is the only plan that offers reduced cost sharing for lower-income enrollees. The data show that Baltimore, Maryland has the largest percentage of change in almost every category from 2018.

KFF's report finds that insurers setting rates for 2019 are taking into account the repeal of the individual mandate and the likely increase of STDL health plans as discussed in the Commonwealth Fund article above. The report confirms the Commonwealth Fund's hypothesis that premiums would increase as a result, given those who leave the regulated insurance market will be relatively healthy on average, in effect increasing premiums in 2019 more than would otherwise be the case.

Healthcare Market Consolidation Raises Competition Concerns

Finally, The Source recently highlighted Source Advisory Board

Member Tim Greaney's 2-part [white paper](#), published by the American Antitrust Institute, on healthcare competition and the issues arising from consolidation in the provider and insurer markets. Read more [here](#).

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!