The Source Roundup: July 2020 Edition

The Source continues to extend wishes of safety and good health to you and your loved ones. As the pandemic causes the healthcare industry financial tragedy, health law experts share important considerations for policymakers, providers, and payers. Many authors hope the pandemic will effect much-needed lasting improvements in the efficiency and efficacy of health care in the U.S.

Antitrust Experts Recommend More Rigorous Regulation of Healthcare Consolidation

In Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States, published by the Source on Healthcare Price & Competition, authors Jaime King, et al. analyze how states could manage and prevent anticompetitive consolidation among healthcare providers and "rampant price increases." The authors studied statutes, regulations, and antitrust enforcement actions in all fifty states and identified five states with the strongest policy and enforcement frameworks: California, Connecticut, Massachusetts, Pennsylvania, and Rhode Island. The authors commend these states for the way they utilize antitrust enforcement tools including notice requirements, pre-transaction review and approval processes, and conditional approvals with post-transaction monitoring protocols. Based on best practices from these states, the authors urge policymakers to consider implementing a tiered framework that would require notice for all healthcare provider transactions and different levels of review for different types of transactions. In addition, they emphasize that states must pair clear statutory regulation with proper enforcement to

effectively prevent the most vulnerable populations from the potential adverse effects of healthcare consolidation.

Another recent article published by *Washington Monthly* , Can COVID-19 Get Congress to Finally Strengthen U.S. Antitrust Law?, calls for increased federal oversight of anticompetitive mergers. Authors Robert H. Land and Sandeep Vaheesan blame mergers for weakening both the nationwide response to COVID-19 and the economy's resilience. The authors claim consolidation tolerance stems from "myths," or common misconceptions about the benefits and need for mergers, which they attempt to refute. They cite examples in which the Department of Justice and Federal Trade Commission failed to preserve competition, including how hospital consolidation continues to escalate healthcare costs. They propose the federal government regulate acquisitions more stringently and provide aid for small or suffering business instead of continuing to allow market concentration.

Public Option Scenarios Could Impact Health Insurance Markets in Unexpected Ways

In Public Options for Individual Health Insurance, Jodi L. Liu et al. evaluated the effects four hypothetical federal public option health insurance plans would have on federal government spending, national overall coverage rate, individual market enrollment, and premiums. *RAND Health Care* published the study, which operated on assumptions including that the public option would have four tiers of coverage, providers would contract lower payment rates, adequate provider networks would form, etcetera. Their microsimulation predicted public option premiums between ten and twenty percent lower than their private market counterparts. In addition, all four options lowered federal government spending by $7 to $24 billion. One hypothetical scenario saw the uninsured rate decrease by 2.8 million people, compared to only a marginal decrease in

another scenario, and 1.1-1.2 million decreases in the remaining two scenarios. While each model predicted modest decreases in the overall number of uninsured persons, making some individuals "better off," the study predicted a significant number of people would become "worse off" under each model. That is, currently insured individuals would either become uninsured or pay more for equivalent health insurance. Lastly, the study found higher-income individuals, who can fully finance insurance out of pocket, were more likely to benefit than lower-income individuals. The authors suggested the federal government could invest its savings to make the public option benefit lower-income individuals via tax credits or other incentives.

COVID-19 Treatments Will Cost Private Health Insurers Billions

As the pandemic persists, *Wakely Consulting Group, LLC* developed and published a report, COVID-19 Cost Scenario Modeling: Treatment, on the potential financial costs private domestic insurers will suffer from COVID-19. Though authors Michael Cohen and Julie Peper admit uncertainty remains surrounding long-term impacts, they assembled updated data as of May 10 from reputable public data sources including the Center for Disease Control and Prevention, the Kaiser Family Foundation, and the Centers for Medicare and Medicaid Services Medicare Advantage reports. They analyzed costs, utilization, and deferred care for commercial health insurers, Medicaid managed care organizations (MMCOs), and Medicare Advantage Organizations (MAOs) between 2020 and 2021 and used actual overall population infection rate instead of positive test rates. During the two-year period, the report estimates COVID-19 will cost private insurers between $30 and $546.6 billion and beneficiaries could pay out-of-pocket comprising $2.8 to $48.6 billion of the costs. The use of three unique possible infection rate scenarios – ten, twenty, and sixty percent – explains the large difference between the lowest and

highest cost estimates. The authors also note these data will likely evolve quickly and insurers may save expenses on non-COVID-19-related treatments.

Telehealth Consultations Between Physicians Benefit Everyone Involved

In Electronic Consultations (eConsults): A Triple Win for Patients, Clinicians, and Payers, published by *Milbank Memorial Fund*, Aasta Thielke and Valerie King report on the Medicaid Evidence-based Decisions (MED) Project findings. They analyzed the effectiveness of eConsults, a type of store and forward technology used by primary care clinicians and specialty clinicians to communicate with each other to provide coordinated care. The report found patient and clinician satisfaction increased, while use of resources were more productive. For example, when a primary care clinician turns to a specialist through an eConsult, they can perform any tests the patient may require prior to seeing the specialist. This saves time and costs for the patient and provider by reducing the number of specialist visits by at least one. Studies estimated eConsults reduced total cost of care by up to eighty-three percent and average specialty-related episode cost of care by $82 per patient per month across four specialties. The authors presume that the widespread use of eConsults could increase access, resourcefulness, coordination, and satisfaction with specialty care as long as fee-for-service policies do not induce reimbursement misuse.

Germany's System Could Help the U.S. Learn How to Control Pharmaceutical Prices

The *New England Journal of Medicine* published Lower Prices and Greater Patient Access — Lessons from Germany's Drug-Pricing Structure, in which James C. Robinson examined pharmaceutical

price discrepancies between two countries despite their numerous other similarities. He highlights that the U.S. and Germany enjoy similar average household incomes, rely on both private and public health insurance plans, prefer negotiation instead of regulation, and determine new drugs' prices with similar uses of clinical assessments. Important differences between the two systems emerge *after* new drugs initially enter the markets. First, regulation in the U.S. allow manufacturers to increase prices as often as twice per year, while the German system prohibits unilateral price increases after the original clinical assessments and price negotiations. Second, while a small population of very sick patients who require high-cost drugs comprise most of the pharmaceutical spending in both countries, patients and health plans experience disparate costs. Insurers in the U.S. try to administratively avoid enrollees from this expensive population, whereas Germany protects these patients by statutorily capping cost-sharing at about $11 per prescription. Robinson suggests the U.S. learn from the negotiation processes between competing health insurance plans and ample statutory structure Germany uses to construct a more socially and economically respectable system for drug-pricing.

If you find additional articles that you would like us to include in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.