

The Source Roundup: June 2021 Edition

The election of Joe Biden to the presidency could mean expanded access to healthcare coverage and increased government regulation of anticompetitive mergers and other practices. Already, Biden and Congress have increased access by temporarily expanding eligibility for health plan premium tax credits. Are other changes on the horizon? This month's Roundup covers research on 1) the potential fiscal impacts of expanding eligibility for Medicare, 2) the views of a key stakeholder in conversations about expanding government's role in providing care and regulating competition, 3) the potential savings that could be generated by increased drug price transparency, 4) the impacts of private equity investment in the healthcare sector, and 5) the costs of vertical integration.

Healthcare Cost Containment

As a candidate, President Joe Biden proposed lowering the eligibility age for Medicare to 60. Meanwhile, Senate Democrats have reintroduced a proposal to allow people ages 50 to 64 to buy in to Medicare. In a new brief, the Kaiser Family Foundation's Matthew Rae, Cynthia Cox, Krutika Amin, and Tricia Newman discuss ["How Lowering the Medicare Eligibility Age Might Affect Employer-Sponsored Insurance Costs"](#) (Peterson-KFF Health System Tracker). The upshot: Moving older adults into Medicare could lower employer plan costs by 15 percent to 43 percent. The findings may not be surprising, given the fact that older adults tend to have higher medical costs than younger people. The authors caution, however, that even if adults under age 65 were given the option to move from an employer plan to Medicare, there's no guarantee they would

elect to make the switch. The savings could be considerably less, they warn, if sicker adults choose to stay on their employer-sponsored plans.

In a related brief, ["Health Spending for 60-64 Year Olds Would Be Lower Under Medicare Than Under Large Employer Plans,"](#) Kaiser Family Foundation's Matthew Rae, Juliette Cubanski, and independent consultant Anthony Damico take a closer look at the potential fiscal impacts of Biden's campaign trail proposal to reduce the eligibility age for Medicare to 60. The authors found that on a per-person basis, private plan spending for 60- to 64-year-olds is 38 percent higher than traditional Medicare spending for 65- to 69-year-olds. Rae et al. say that lowering the Medicare eligibility age to 60 would likely reduce revenues for hospitals, doctors, and other providers who care for this patient group. For example, large employer plans pay as much as 2.5 times the Medicare rate for the same type of inpatient admission—a differential that is increasing, the authors say. On the other hand, lowering the Medicare eligibility age to 60, they say, could save patients and employers money, and could also save money for the federal government in the form of reduced subsidies for employer-sponsored coverage.

A new survey gauging corporate executives' views on increased government involvement in providing health care coverage and reducing costs yielded a surprising result: A majority agreed that greater government involvement is needed. In a Kaiser Family Foundation brief detailing the findings, ["How Corporate Executives View Rising Health Care Cost and the Role of Government"](#), researchers Gary Claxton et al. found that 87 percent of the more than 300 big company executives they surveyed felt that the cost of providing health benefits to employees will become unsustainable within the next decade, and that a similar number felt that more government intervention is needed. With respect to more specific interventions, the vast majority of respondents supported

increased price transparency, increased antitrust enforcement, or prohibitions on anti-competitive conduct. Smaller majorities backed the concepts of lowering the eligibility age for Medicare and creating a public option. The researchers' goal was to gauge the mood of a key constituency in what is likely to be a messy fight over efforts to rein in health care costs and increase access to coverage. While on the campaign trail, President Biden had proposed reducing the Medicare eligibility age to 60 and creating public option. The brief also notes bipartisan support for stronger antitrust enforcement and curbing anti-competitive behavior, including price caps for high-cost drugs.

Pharmaceuticals

Requiring pharmacies to report their drug purchase costs to the federal government could generate up to \$10 billion in savings to the Medicaid program over the next decade, according to a new issue brief. In ["The billions in prescription drug savings from enhancements to NADAC,"](#) researchers from 3 Axis Advisors determined that such savings could be generated if pharmacies were required to report drug purchase costs to the Centers for Medicare & Medicaid Services' National Average Drug Acquisition Cost (NADAC) pricing benchmark, which is used to help state Medicaid fee-for-service programs meet federal requirements for reimbursing pharmacies. Reporting is voluntary under current federal law but would be mandated by a bipartisan bill reintroduced in Congress in 2020, the Prescription Drug Pricing Reduction Act. The bill was referred to a Senate committee in July 2020, but no action has been taken on it since that time. Because only 20 percent of pharmacies report their drug purchase prices to the national survey, it lacks price information for some drugs and may not capture certain pharmacies, such as national chains. Traditional pricing benchmarks reflect higher costs than the actual costs that participants in the drug supply

chain may be paying—particularly for generic drugs—creating a potential windfall for those participants. Extrapolating from Alabama’s benchmark survey—which requires pharmacy participation—the report determined that Medicaid programs could see drug costs drop by nearly 20 percent compared to current NADAC pricing if such reporting were mandated.

Healthcare Market/Competition

Fewer than half of patient care physicians worked in a private practice wholly owned by physicians, data from the American Medical Association’s 2020 Benchmark Survey show. According to a Policy Research Perspectives paper by Dr. Carol K. Kane, [“Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020,”](#) this is the first time the percentage of doctors in a physician-owned private practice dropped below 50 percent. The benchmark data includes responses from some 3,500 physicians in more than 250 specialties. According to Kane, the percentage of doctors who owned their practice has been sliding since the 1980s, when the AMA began conducting surveys. Separately, while only four percent of doctors reported that their practice was under private equity ownership, that number rises to 10 and 15 percent for emergency medicine and anesthesiology practices.

As private equity acquisition rises in healthcare markets, policy researchers begin to examine its impact on the price and quality of care. [“Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk”](#) (American Antitrust Institute/Petris Center), a new report by Richard M. Scheffler, Laura M. Alexander, and James R. Godwin, found that private equity’s focus on short-term profit generation and consolidation can undermine patient care, destabilize markets, and accelerate consolidation. The report offers case studies

of private equity acquisitions of health care entities—and a call to action for greater government oversight. Scheffler et al. note the value of private equity investment in healthcare nearly tripled between 2010 and 2019. Moreover, they point out that this number is likely understated as most of the deals don't have to be reported to regulators. In addition to calling on federal regulators to require reporting and approval of private equity acquisitions, the authors shine a light on state and federal legislative efforts to address concerns about such acquisitions.

Hospital and health system ownership of physician practice groups equals higher Medicare spending for services, according to ["Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration,"](#) a new *Health Affairs* article by Christopher M. Whaley, Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg. The researchers found that vertical integration led to an additional \$73 million in Medicare costs for common imaging and laboratory tests. Whaley et al. examined Medicare fee-for-service claims data for the years 2013 to 2016. According to the article, the number of hospital-based diagnostic imaging and lab tests rose following vertical integrations, while the number of tests performed in a non-hospital setting dropped.

That concludes this month's Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please [send](#) them our way. Stay safe and healthy!