

The Source Roundup: March 2019 Edition

Happy March! This month we take a look at articles that examine 1) state health system reform efforts, 2) protections against surprise medical bills, 3) effects of market concentration on cost and quality, and 4) ways to control rising costs for health care and pharmaceuticals.

States are taking the lead in health system reform

While the federal health policy debate has remained rather stagnant, states have stepped up to protect their citizens from rising health care costs. North Carolina is poised to make rapid, unprecedented changes to its provider payment system. In a *Health Affairs* blog post, [North Carolina: The New Frontier For Health Care Transformation](#), Mark McClellan et al. discuss the State's plan to transition 70% of its health care payments to alternative payment models, with the dual goal of lowering the cost while increasing the quality of care for patients. Blue Cross and Blue Shield of North Carolina also published an article in *NEJM Catalyst* titled [Engineering a Rapid Shift to Value-Based Payment in North Carolina: Goals and Challenges for a Commercial ACO Program](#), which details how it plans to transition its 4 million members in the State to accountable care organization programs.

In California, following Governor Newsom's health proposals, Doctors Richard Scheffler and Stephen Shortell published their white paper, [California Dreamin': Integrating Health Care, Containing Costs, And Financing Universal Coverage](#). They propose to move California to universal coverage by using risk-based capitated care delivery models. If implemented, the authors estimate that the plan would provide coverage for 3.5 million people at a cost of \$17.3 billion.

Back in 2010, Rhode Island implemented their system reform policies, and a recent study touted their success. Conducted by a group of six health care academics, the study found that [Health Care Spending Slowed After Rhode Island Applied](#)

[Affordability Standards to Commercial Insurers](#). Aaron Baum et al. detailed that Rhode Island imposed annual price inflation caps on inpatient and outpatient services, transitioned hospital payments from per diem payments to value-based payments and payments based on diagnosis-related groups, and increased spending on primary care. Together, these policies resulted in a more than 8% decline in health care prices for consumers.

Scholars weigh in as federal and state legislatures debate surprise balance billing protections

After surprise bills made headlines last year, Congress is debating a bipartisan piece of legislation which would impose caps on out-of-network charges. Leading scholars on the issue, Loren Adler, Mark Hall, Erin Trish, and Paul Ginsburg, examine the federal bill in [Analyzing Senator Hassan's Binding Arbitration Approach To Preventing Surprise Medical Bills](#), and discuss other proposals in an article for the *New England Journal of Medicine*, [Reducing Unfair Out-of-Network Billing — Integrated Approaches to Protecting Patients](#). Alder et. al also recently published a white paper, [State Approaches to Mitigating Surprise Out-of-Network Billing](#), which should inform state legislative debates on the issue. The paper compares regulations of billing practices alone versus a combination of billing and provider contracting regulations.

Medicare and Medicaid are better than private insurers at containing costs

In terms of cost containment, a *Health Affairs* research article by Zack Cooper et al. analyzes [Variation In Health Spending Growth for the Privately Insured From 2007 to 2014](#). It found that while private health spending per enrollee increased by almost 17% over the seven-year period, Medicare fee-for-service spending *decreased* by 1.2%. John Holahan and Stacey McMorrow also discuss similar trends in their report, [Slow Growth in Medicare and Medicaid Spending Per Enrollee Has Implications for Policy Debates](#). These findings are particularly important given the *Health Affairs* research article [National Health Expenditure Projections, 2018-27:](#)

[Economic And Demographic Trends Drive Spending And Enrollment Growth.](#)

According to the authors Andrea M. Sisko et al., health expenditures will represent almost 20% of the United States' GDP by 2027, so it is important that policymakers consider the ways that Medicare and Medicaid have demonstrated efficacy in containing health costs.

[Market concentration leads to higher costs, lower quality](#)

Two recent articles considered market power influences on hospital quality and costs. A group of researchers led by Zack Cooper found that [Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007-14.](#) While both hospital and physician prices increased, hospital prices grew much faster than physician prices due to the dramatic increase in facility costs as a result of market consolidation. The report recommends that policymakers focus on options to contain hospital and facility prices in order to address overall rising costs, including antitrust enforcement and the use of reference pricing. On the other hand, authors Marah Noel Short and Vivian Ho assess the quality of care in hospitals in their article, [Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality.](#) They conclude that increasing market concentration leads to patient dissatisfaction. Taken together, these articles indicate that as hospitals become larger market forces, they make care more expensive and less efficient for patients. Short and Ho conclude that regulators should carefully scrutinize proposed hospital mergers, and reduce barriers to entry to increase competition, thereby driving down costs and increasing quality.

The Commonwealth Fund's article [Market Concentration and Potential Competition in Medicare Advantage](#) is another article concerning competition and barriers to entry. In this article, Richard Frank and Thomas McGuire analyze data from the past ten years and conclude that Medicare Advantage markets have become regionally dominated by two or three insurers, resulting in higher prices for Medicare Advantage enrollees. Frank and McGuire point to six possible entrants to the Medicare Advantage market and stress the need for further research about why they are being prevented from entering the market.

A look at Medicaid pharmaceutical spending and ways to drive down costs

Most people are aware of the rapid rise of prescription drug costs in the United States, but Katherine Young takes a closer look at Medicaid pharmaceuticals in her issue brief, [Utilization and Spending Trends in Medicaid Outpatient Prescription Drugs](#). Over the studied three-year period, Medicaid spent an increasing proportion of its budget on pharmaceuticals before rebates, and Young projects that it will continue to increase over the next ten years. Young points to the high cost of patented pharmaceuticals as the cause, as the vast majority of Medicaid pharmaceutical spending went to expensive brand name drugs, even though the most Medicaid patients got generics.

In response to ballooning prescription drug prices, *The Commonwealth Fund* article [Reference Pricing in Germany: Implications for U.S. Pharmaceutical Purchasing](#) proposes a possible solution. Authors James Robinson, Dimitra Panteli, and Patricia Ex look to the German reference-pricing system in comparison to the tiered drug formularies and consumer cost-sharing systems in the United States. Because the German health system is proven effective at containing costs and also uses multiple private payers and negotiation to establish drug prices, the article posits that the German model is the best one for the United States to implement in order to drive down prescription drug prices.

That's it 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. Happy reading!