The Source Roundup: October 2018 Edition

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Welcome to October! We hope you are getting your costumes picked out and finding those deals to stock up on trick-or-treat candy. In this edition of The Source Roundup, we review five academic articles and reports from September that stood out to us. This month we look at (1) price inflation in the California fully-insured large group market, (2) forward motion in drug price transparency laws, (3) the future of pharmaceutical reference pricing in the U.S., (4) lessons learned from California's competitive healthcare model, and (5) paths to universal coverage in California.

Data Shows Price Inflation of Provider Services, Not Utilization, Drives Premium Costs in the Fully-Insured Large Group Market

In a recent report "It's Still the Prices: Second Year Data from California's Rate Filing Law Reveals Prices, not Utilization, Continue to Drive Premium Costs in the Fully-Insured Large Group Market," prepared by the California Labor Federation, sponsors of California's rate filing legislation (SB 546), the authors report that within California's fully-insured large group market, premiums continue to outpace inflation, provider costs continue to drive costs at a greater share than pharmaceuticals, and price of provider services contributes more to rising premiums than service utilization. California Labor Federation believes this year's findings, combined with last year's, "strongly suggest" that state regulators "must act to sharply regulate provider prices" to control insurance premiums within the fully-insured large group market.

The average price inflation between California's top seven insurance companies was 166% of California's inflation rate. The reported average increases in premiums ranged from Kaiser's 3.5% to Aetna's 11.6%. The report also showed that hospital costs and provider services made up 75% of projected monthly premiums, demonstrating the outsized effect of provider's cost on premiums. Probably most

compelling, was the comparison the authors drew between the price increase and a lack of increase in utilization. Kaiser, for example, reported in the 2017 report that "*all* of its projected increase[]" was an effect of service price increases. Notably, Kaiser accounts for 4.9 million covered lives in California,or 58% of the entire market, and none of their increase was attributed to an increase in service utilization. While ultimately the authors are merely reporting their findings after an analysis of the filings submitted to both the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), they also make a call to action to California state regulators. Although, there is no mention of what regulatory actions they would recommend.

California Threads the Needle Through Regulatory and Case Law Hole in Attempt to Move Prescription Drug Transparency Law Forward

In their recent article, published in the September issue of Health Affairs, "California's Drug Transparency Law: Navigating The Boundaries Of State Authority On Drug Pricing", The Source's own Katherine Gudiksen and Jamie King, along with Timothy Brown and Christopher Whaley, walk readers through the dark and spooky forests of state authority in regards to pharmaceutical drug pricing transparency, specifically California's drug transparency bill, SB-17. Gudiksen et al. note that SB-17 was carefully designed to skirt the edges of state authority and "promote transparency in pharmaceutical pricing" by requiring drug price disclosures by both insurers and drug manufacturers.

The article lays out the existing specters SB-17 faced from the outset from the federal Employee Retirement Income Security Act (ERISA) and the pharmaceutical industry based on trade secret protections. While ERISA has an exception for state insurance regulation, it fails to recognize self-insured employerbenefit plans as insurance, thereby treating those self-insured plans as "employee benefit plans" and preempting the state from passing laws to regulate health plans which cover 60% of all Americans. Then the authors describe the pharmaceutical industry's recent attempts to carve up California's drug price transparency law on constitutional grounds, specifically for violating the dormant commerce clause, free speech, and due process. There is considerable uncertaintyin how the District Court for the Eastern District of California will decide these issues, but any decision will help to

provide much neededclarity for future drug pricing legislation. The authors make it clear that SB-17 may not have a significant impact on drug prices. However, they see the passage of this law, and to a greater extent, the survival of SB-17 against legal challenges as a "meaningful step" toward defining the boundaries of state authority in attempts to affectpolicy change in healthcare.

Challenges of Applying Reference Pricing to Pharmaceuticals

In his article published by The Commonwealth Fund, "Pharmaceutical Reference Pricing: Does It Have a Future in the U.S.?", James Robinson examines the application of reference pricing to pharmaceuticals. As a replacement for tiered drug formularies and common in health plans in the U.S., reference pricing offers enticing reductions in health plan spending. The author gives the example of a private employer coalition that has applied this novel benefit design to its pharmaceutical plan and experienced an average price reduction of 14%. However, Robinson is quick to point out that reference pricing is not the silver bullet to controlling pharmaceutical costs it may appear to be. This is due to limitations inherent in this method, such as (1) a requirement of vast and current drug pricing and information from enrollee distribution points (e.g. retail pharmacies, mail order channels) to "appropriately motivate price-conscious consumer choice"; (2) collection and access to drug efficacy information when reference pricing is applied to heterogeneous procedures or classes of drugs; (3) and the model's sole fixation on drug price with no accommodation for a drug's appropriateness for the patient's condition. Furthermore, Robinson notes that pharmacy benefit managers (PBMs) seem to be the main block to widespread adoption of this benefit design model, because of PBMs' complicated business models in which they benefit when enrollees purchase high-costdrugs rather than lower cost options. Since reference pricing shifts the financial risk to enrollees that purchase high-costdrugs, enrollee purchasing behavior naturally shifts to lower cost options, thereby removing much of the profits that PBM business models are based on. In order for the U.S. to see wide adoption of reference pricing for pharmaceuticals, Robinson suggests that in addition to addressing the limitations of reference pricing as a benefit design, PBMs must also innovate their business model and find ways to "document and take credit for the associated savings" and get paid for providing their services.

Looking back at California's Competitive Model for Controlling Health Care Cost

Despite early success, a series of policy and enforcement choices has left California's competitive model of controlling health care cost uncompetitive. This is the thesis of Glen Melnick, Katya Fonkych, and Jack Zwanziger's article, published in the September issue of Health Affairs, "The California Competitive Model: How Has It Fared, And What's Next?", and their data is very compelling. In the early 1980s, California shifted to a provider competition model that employed managed plans and selective contracting in commercial health plans. The goal was to allow commercial health plans to "leverage market conditions and keep prices low." Melnick et al. say that the data suggests the model worked initially, with a cumulative 26% reduction in prices paid by health care plans to hospitals from 1995 to 1999; however, subsequent data tells a different tale we are all too familiar with. Between 2001 and 2016, commercial health plans saw a nearly 238% increase in payments to hospitals, even though there was a 10% decrease in the totalvolume of services.

The authors attribute the drastic change to policy changes in response to aggressive management of utilization and narrower provider networks. First, hospital prices increased due to adoption of the prudent person rule. Enacted to improve access to care and protect patients from out-of-network costs when seeking emergency medical treatment, the "prudent layperson" rule required health plans to pay for their members'emergency room services regardless of whether the health plan was in contract with the hospital. Since health plans could no longer deny payment for out-of-network emergency services, hospitals increased their service costs. In addition to policy changes, hospitals responded to the increased competition that aggressive managed care plans brought to the provider market by consolidating into large hospital systems. With their increased market share leverage,they began using anticompetitive contracting practices. The impact of this "anticompetitive contracting" was that these large hospital groups saw an average price per admission of $7,000 more than other California hospitals.

Based on this data, the authors challenge the current policy and enforcement stance in California and suggest that policymakersshould (1) look at new approaches to

limit providers' ability to take advantage of the prudent layperson rule while maintaining access to care and (2) step up enforcement of antitrust regulation to promote more robust competition in all healthcaremarkets.

Is There a Way to Implement Universal Coverage in California? Technically, Yes.

California is described as a "vanguard" of the universal coverage movement in America by Andrew Bindman, Marian Milkey, and Richard Kronick in their Health Affairs article, "Beyond The ACA: Paths To Universal Coverage In California." Bindman et al. examine the most likely paths to universal coverage that California could take, as the momentum from ACA coverage gains and the threat of backsliding introduced by the Trump administration has relit the universal coverage debate. The two possible paths described are (1) a systematic filling of coverage holes within California's current fragmented coverage system, or (2) a system of unified public financing where "all Californians would receive health care coverage by virtue of residency,"and the "distinctions between Medicare, Medicaid, employer-sponsored, and individual market coverage would be eliminated." The second path would be a fundamental change in the way health care is delivered and paid for and would be the most disruptive solution to the current model. It would require unprecedented political cooperation at both the state and federal level, not to mention sweeping changes in established laws. For example, taxes would need to be created to replace the employer and individual premium contributions currently paid to health plans, and amendments to the California constitution would be required to implement unified financing in the state.

With all of this disruption, lawmakers seem to prefer to increase coverage through state action alone. California's state assembly did not take up SB 562, California's single-payerbill that was passed by the California Senate during the 2017-2018 legislative session. However, they are introducing bills that would expand coverage for undocumented adults and fund the development of a task force to examine other options to expand coverage. The authors note that current policy debates often start out with grand visions of "sweeping reform,"but inevitably, practical and political challenges "give way to accepting incremental change."

In addition to the articles above, we recommend taking a peek at a few other articles published in the September special issue of Health Affairs that focused on health care in California. For example, in "Consolidation Trends In California's Health Care System: Impacts on ACA Premiums And Outpatient Visit Prices," Richard Scheffler et al. lookat the market consolidation trends and suggest actions that regulators should take. Also, Alain Enthoven and Laurence Baker examine whether managed competition is still a viable answer to "improving value in health care" in their article "With Roots In California, Managed Competition Still Aims To Reform Health Care." Both articles are well worth the read.

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 sendthem our way. Enjoy your reading!