

# The Source Roundup: September 2018 Edition

Happy September! We hope you've enjoyed the Labor Day weekend and ready for the fall! In this edition of The Source Roundup, we cover five academic articles and reports from July and August. This month we look at (1) monopoly in the ACA marketplace; (2) the recent *Ohio v. American Express* U.S. Supreme Court decision; and a trio of articles that examine accountable care organizations in terms of (3) ACO growth in 2018; (4) ACO effectiveness in reducing health care costs; and (5) the proposed changes to ACOs in the Medicare Shared Savings Programs.

## **The Association Between Monopolistic Insurers and Increased ACA Marketplace Premiums**

In the Health Affairs research article "[ACA Marketplace Premiums Grew More Rapidly in Areas With Monopoly Insurers Than in Areas With More Competition](#)," Jessica Van Parys proposes three theories as to why premiums in certain state rating areas have increased rapidly since 2014. The first theory posits that before the Affordable Care Act (ACA), some areas had sicker uninsured consumers. Premiums then became higher in those areas once the sick, uninsured population entered the ACA marketplace. The second theory hypothesizes that providers with a greater market share were in a position of power to negotiate higher prices from insurers, which caused insurers to pass those increases onto consumers in the form of higher premiums. The final and, according to the author, most likely theory is based on insurer market power. Using data from five databases, the author concludes that competition is a major influence on premiums. Areas with monopolist insurers have premiums that are 50 percent higher than those with more than two insurers due to large premium increases in the lowest-cost plans.

The author then offers two explanations for the relationship between premiums and insurance competition. Under the framework of the "risk selection" theory, healthier low-cost consumers enroll with Insurer A, and sicker, high-cost consumers enroll

with Insurer B. This forces Insurer B to exit the market because it is faced with two financially unviable options: to have low premiums that would not mitigate the increase in high-cost enrollees, or to increase its premiums which would drive away the cheaper healthier enrollees to Insurer A. The author believes the “insurer market power” theory provides a stronger explanation for why premiums increase when competition decreases among insurers. The theory postulates that some insurers became monopolistic because they underpriced premiums when the ACA marketplaces were first created. This move enabled them to drive competitors out of the market and then increase their premiums. Ultimately, the author concludes future reforms of the individual market would be more effective if legislators fully understood the importance of competition among insurers.

### **The Potential Implications of *Ohio v. American Express* for the Healthcare Community**

The U.S. Supreme Court (SCOTUS) recently issued a landmark decision in *Ohio v. American Express* that could theoretically impact anticompetitive efforts in the healthcare market. Marcia Boumil and Gregory Curfman investigate how the healthcare community should pay great attention to this seemingly unrelated antitrust dispute in the Health Affairs article [“Will Insurance Companies Be Able to “Steer” Patients to and from Providers?”](#) In *Ohio v. American Express*, the Court applied a new relaxed antitrust analysis in which the court must evaluate the anticompetitive effects an intermediary’s actions have on both sides of a two-sided “platform” industry as a single transaction. In a “platform” industry, a single intermediary, such as American Express, negotiates with both sides of a two-sided transaction, specifically when the credit card company offers incentives to cardholders while charging the merchant a credit card processing fee at the same time.

In the SCOTUS case, American Express’ contracts with merchants prohibited the merchants from “steering” consumers to use a lower processing fee credit card over the higher processing fee American Express credit card. The Court found insufficient evidence to support the federal and state governments’ argument that anti-steering

provisions limited competition for merchants. Justice Breyer's dissent blasts the majority's new legal standard for evaluating antitrust claims in platform markets and fears the ruling could allow companies to flex their market power so long as there is some proven benefit to consumers on either side of the transaction. Amicus curiae American Medical Association and Ohio State Medical Association (collectively AMA) likewise agree with the dissent's concern regarding the ruling's impact on other platform markets, particularly in the health care context where the insurers are the intermediaries who negotiate with provider networks on the one side and employers on behalf of their employees (the patients) on the other side. The authors fear that health insurers could interpret the ruling to empower themselves to include "anti-referral" clauses in provider contracts, thereby restricting expensive out-of-network referrals and advanced diagnostic tests. Although it is still speculative whether *American Express* could adversely impact health care competition, pricing, and quality of care, they believe the majority's ruling opens a new line of legal theory that health insurers could take advantage of to mitigate their costs at the expense of a patient's right to quality, unencumbered care.

### **Reviewing ACOs' Growth in 2018**

Accountable Care Organizations (ACOs) is the hot topic this month as we look at a trio of recent articles that examines the growth, outcome, and prospect of ACOs. First, David Muhlestein et al. examine how ACOs and value-based payment models have grown in 2018 in the Health Affairs article, "[Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018.](#)" The authors found that, since 2017, the overall numbers of ACOs and ACO contracts have increased, with 10 percent of the U.S. population covered by an ACO. Medicare ACO contracts saw more growth than commercial or Medicaid contracts, but the authors attribute the minimal growth in commercial and Medicaid contracts with the change in federal administration. Due to limited new options to participate in alternative Medicare value-based payment arrangements in 2017, other active demonstration models have remained stagnant or slightly declined in participation levels; however, the Centers for Medicare & Medicaid Services (CMS) will implement a new alternative payment model demonstration, Bundled Payments for Care Improvement

Advanced. The authors believe this should inject more participation in episode-based payment contracts. Although some healthcare policy experts see an increase in ACOs as a sign of achieving lower health care costs and better quality of care, the authors assert the lack of program guidance as the biggest barrier to implementing fundamental administrative and clinical operations reforms. Looking ahead, the authors believe progress in care reform can be achieved more quickly if payment models are refined and providers learn from ongoing successful organizations.

### **Are ACOs the Best Value-Based Care Reform?**

In the NEJM Catalyst case study, "[Hospital-based ACOs Face Challenges in Tracking Performance Indicators](#)," Christina Beveridge et al. investigate the outcome of ACOs by examining why ACOs have only achieved limited success in reducing health care costs and improving quality of care even though the number of ACOs have increased over the years. ACOs were designed to create financial incentives for physicians to provide quality coordinated care while minimizing unnecessary utilization. However, the authors found that hospital-based ACOs lacked the resources to consistently track and share essential performance metrics, such as patient satisfaction, financial metrics, utilization metrics, and clinical quality indicators. ACOs are most successful if providers know the baseline services patients are using and what the costs are. Therefore, the authors assert that because of a lack of a uniform health information exchange among provider organizations, ACOs are unable to adjust and provide higher quality care coordination and reduce wasteful utilization. Finally, there are significant operational and technological challenges that prevent physicians from implementing changes in their prescription and referral patterns. Many ACOs must present aggregate facility-level data to CMS rather than individual-level performance metrics. Provider-level data would better inform physicians as to what services patients are using across multiple health care systems. The authors propose bundled payments as a more successful value-based care reform than ACOs because hospitals can narrowly track defined episodes of care rather than individual patient care.

## **CMS Administrator Breaks Down Proposed Changes to Medicare Shared Savings Programs**

Lastly, CMS Administrator Seema Verma provides insights to the future of ACOs with proposed changes to the Medicare Shared Savings Program (MSSP), which houses the majority of Medicare's ACO initiatives. In a post published by Health Affairs titled "[Pathways to Success: A New Start for Medicare's Accountable Care organizations](#)," Verma details proposed changes that seek to increase quality of care to patients and decrease program spending, saving Medicare up to \$2.2 billion over 10 years. The plan lays out several major changes related to ACO accountability, competition, beneficiary engagement, program integrity, and service quality. First, administrative costs will decrease if: (1) the number of tracks available to ACOs are consolidated to two tracks that contain different levels of risk; (2) ACO participation agreement lengths are extended from 3 to 5 years; and (3) the transition to "two-sided" risks is expedited. Then, CMS proposes requiring ACOs to provide a standard notice of ACO benefits available to beneficiaries at their first primary care visit, which includes possible incentive payments for proactively maintaining good health with preventative care services. Next, ACO providers will receive payments for expanded telehealth services, allowing more patients to receive high-quality services at a low cost. Finally, ACO benchmarks would incorporate county-level spending and national spending growth rates. Under these proposed changes, ACOs in "two-sided" models will be held accountable for their losses and terminated if they have multiple years of poor financial performance. Verma encourages the public to submit comments on the [proposed rule](#) until the public comment period closes on October 16, 2018.

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!