
THE INSIDER'S GUIDE TO Health & Drug Benefits®

MARCH 2024

Covered Preventive Services at Risk: V-BID Summit Breaks Down the Braidwood v Becerra Case

By Laura Joszt, MA

From the earliest days of when the Affordable Care Act (ACA) was being drafted to the day it was approved, a preventive services provision was a major goal to reduce cost barriers to the interventions that were proven to save downstream costs, explained Nick Bath, partner, health, law firm Manatt.

However, this year, required coverage of preventive care services under the ACA is at risk due to the lawsuit *Braidwood v Becerra*, which was at the heart of session that took place as part of the University of Michigan Center for Value-Based Insurance Design (V-BID)'s 2024 V-BID Summit. The theme of the V-BID Summit was "Overcoming Financial Toxicity," and coverage of preventive care services at low or no cost can play a key role in doing so.

Bath was joined by Anand Parekh, MD, chief medical advisor, Bipartisan Policy Center, who provided the background on prevention and the importance of giving people access to preventive services, such as immunizations, cancer screenings, or substance abuse counseling, and other services that organizations like the US Preventive Services Task Force (USPSTF) have identified as being high value.

"These services save lives, they improve health, they reduce illness burden, and they really work," he said.

However, uptake of these services in the US is poor, he added. The US does well at cardiovascular screenings, but

uptake for substance use, mental health, and depression screenings are low, and immunizations are down across the board, according to Parekh.

The US has had low uptake of high-value, evidence-based clinical preventive services for a long time in both the commercial and Medicare sector, and there are a lot of reasons for that, one of which is the cost. Since the ACA was passed, research has shown that removing cost sharing from preventive services increased screening for color cancer, high blood pressure, and high cholesterol; increased vaccinations for the flu and human papillomavirus; and increased use of contraception.

"Not only that...the use of preventive services [has particularly] increased amongst those who are financially vulnerable, as well as minority populations," Parekh said. "That's what makes this case, *Braidwood v Becerra*, so important, because we know that these are really impactful services."

The worst-case scenario, should the plaintiffs in the case prevail in removing the requirement that insurers, would be the US going "back to the Wild West," he said, in which plans set their own rules and guidelines. However, with research showing the benefit to plan members when preventive services are available with no cost barriers, a lot of the major health plans have said they support covering these services, according to Parekh.

"Worst-case scenario, you could go back to the days where I may recommend, as a clinician, 'it's now important to get your colorectal cancer screening,' and the response might be, 'well, I don't have the \$500 to pay for that,'" Parekh explained. "And that's exactly what we were trying to get away from with this ACA provision."

The *Braidwood v Becerra* case alleges that the USPSTF doesn't have the specific power to deem certain preventive services require no cost in the commercial market, explained Bath. The argument is that the provision is unsound under the appointment clause, which requires certain officials performing certain tasks be appointment by the president and confirmed by the Senate or appointed by a Cabinet secretary.

In addition to ruling on the question of USPSTF's power, the court also ruled that the Religious Freedom Restoration Act protected the nonprofit Christian-owned Braidwood Management from being required to cover pre-exposure prophylaxis drugs for HIV. The case went onto the Fifth Circuit Court of Appeals, which heard oral arguments early in March.

While the appeals court has not issued a decision, "I think a betting person would say they're inclined to uphold the district ruling on both counts," Bath said. "Much of the questioning during the oral argument surrounded what remedy the court should prescribe."

Assuming the Supreme Court, which leans conservative same as the Fifth Circuit Court of Appeals, will agree, the question arises: how does one cure the appointments clause issue? The solution would have to be legislative and a bipartisan fix required. Coverage of these preventive services has enormous popularity. “They’re baked into the cake now; no one expects to pay for these,” Bath said.

He added that the last 15 years have clearly shown people don’t like it when something they have is taken away, especially in health care. However, there are obstacles. These benefits have been in existence for a long time, but the fact that the cost has disappeared from peoples’ out-of-pocket liability “makes them somewhat invisible,” Bath explained.

“To put it simply, people take [covered preventive services] for granted and may not know where they came from,” he said. “In fact, they probably don’t.”

In addition, there aren’t huge cost saving associated with covering preventive services. The Congressional Budget Office does not want to assign large, downstream federal savings in the form of avoided medical care partly because there is the assumption that insurance plans will continue to cover these services even if the provision goes away.

While there does seem to be evidence that many plans will still cover these services, things change. “What happens when a screening test for cancer arises, for which the price is something unexpected? I think the plan and self-insured [employer] dynamic may look a little different because they have fiduciary duties, not because they’re bad people,” Bath said.

Ultimately, he thinks that after a long appeal, which could take to the end of 2025, the appointments clause issue will land in Congress’ court. However, his concern is that this will no longer be a priority anymore and that there is no bipartisan consensus foundation on which to proceed for addressing the issue.

At the end of the session, Parekh urged attendees to make coverage of preventive care services a top priority. “At the end of the day, we all care about health, and these are services that save lives, they do help.” ■

PAN Foundation Reports the State of Patient Access Among Individuals With Chronic Conditions

By Pearl Steinzor

The state of health care access among patients with chronic conditions was given an overall C-grade rating in a report by the Patient Access Network (PAN) Foundation, which highlighted significant sociodemographic barriers that have contributed to unequal health care access, positive health outcomes, and life expectancy in the US.

The Pan Foundation launched the State of Patient Access initiative in 2024, with the aim of increasing awareness, education, and implementing policy to reduce barriers and disparities that surround access to health care.

“Health care in the United States has become unaffordable and inaccessible for many patients, even those with health insurance and other resources,” according to the report. “Though disparities run deep and wide—rooted in racism and bias, structural inequities, social and economic disadvantages, and systemic inefficiencies—challenges accessing and affording needed health care have become all too common for everyone.”

This research was based on 2 national surveys conducted by The Harris Poll in August to September 2023, which included 2502 patients with chronic conditions and 251 primary care providers (PCPs), 150 nurse practitioners or physicians assistants, and 100 registered nurses.

In this report, the researchers identified 5 key areas where health care challenges exist, including overall access to care, relationships to health care professionals, affordability of prescription medications, access to

treatment through health care plans, and financial toxicity.

The researchers calculated an overall composite index score for all 5 categories, as well as individual scores for each subcategory. These scores were measured at the total patient level and for a variety of patient population subgroups to highlight any disparities in access to care.

In total, the state of health care access was rated a 75.8 or “C” based on the scorecard grades from each category.

Overall access to care received a 78.8 or a “C+”, finding that access is not just challenging for everyone, but it is even worse among historically marginalized communities. Not only did patients report the quality of care they received was poor, but 48% of patients reported facing logistical barriers, such as trouble getting to appointments and financial challenges paying for needed care. Additionally, people of color (57%), younger patients (70%), and LGBTQIA+ patients (77%) were more likely to report experiencing logistical barriers to care.

Trust in health care professionals received an 84.2 or “B” grade, with 96% of patients that said they trust their PCPs, specialists, and nurses. However, 28% of patients reported experiencing interactions with their health care professional in the past 12 months that prevented them from receiving care, and some patients felt that their health care professional did not take their concerns seriously.

Affordability of prescription medicine received an 82.3 or “B-” grade, with challenges especially prevalent among Hispanic, Native American or Pacific

Health care in the United States has become unaffordable and inaccessible for many patients, even those with health insurance and other resources,” according to the report.

Islander, and LGBTQIA+ patients. In total, 20% of patients said their prescriptions were not affordable, and 36% had to take financial steps, such as reducing spending or taking on credit card debt to afford their medications.

Access to treatment through insurance received a 62.8 or “D-” grade, and a failing “F” grade among Hispanic, Native American or Pacific Islander, and LGBTQIA+ patients, as well as younger patients and those with lower incomes.

Financial toxicity received a 70.7 or a “C-” grade, finding that patients of color (31%), LGBTQIA+ patients (41%), and younger patients (36%) were more likely to report higher levels of financial toxicity than others.

These findings help to inform advocacy groups, policy makers, and industry leaders on the disparities and burdens of accessible health care, especially among marginalized communities in the US.

“As an annual, flagship initiative of our new Center for Patient Research, we hope to see improvements in how adults with chronic conditions perceive and experience access to needed care and treatment, year over year,” according to the report. “Because until everyone has access to affordable, equitable health care, we will keep advocating for change.” ■

REFERENCE

State of Patient Access. PAN Foundation. March 19, 2024. News Release. Accessed March 22, 2024. <https://www.panfoundation.org/state-of-patient-access/>.

Experts Issue Call for Reform to DMD Drug Pricing, Trial Approval Process

By Maggie L. Shaw

Five genetically targeted treatments for Duchenne muscular dystrophy (DMD) have received accelerated approval from the FDA since 2016—eteplirsen (Exondys 51; Sarepta Therapeutics), golodirsen (Vyondys 53; Sarepta Therapeutics), casimersen (Amondys; Sarepta Therapeutics), viltolarsen (Viltepso, NS Pharma), and delandistrogene moxeparovec-rokl (Elevidys, Sarepta Therapeutics)—with the government agency basing its decisions about each on results they believe “reasonably likely to predict clinical benefit.” Total annual net spend since 2016 for eteplirsen, golodirsen, and casimersen alone is an estimated \$3.1 billion, ballooning from \$7 million in 2016 to \$879 million in 2022.

Experts from the Division of Pharmacoepidemiology and Pharmacoeconomics, Brigham and Women’s Hospital, in Boston, publishing their findings in *JAMA*, highlight that this exorbitant total is despite a lack of confirmatory trials, in spite of scant evidence of efficacy, and even though not all patients who have DMD are eligible. For example:

The confirmatory trials for eteplirsen, golodirsen, and casimersen remain unfinished, with original FDA deadlines of November 2020, April 2024, and April 2024, respectively, and new expected completion dates of November 2024, October 2025, and October 2025

Results from delandistrogene moxeparovec-rokl’s trial, completed in October 2023, show it did not improve functional mobility scores vs placebo

Viltolarsen’s end data are in but remain unknown; the confirmatory trial was completed in October 2023

Their present analysis of estimated public and private spending—comprising rebates and statutory Medicaid/340B discounts—focused only on eteplirsen, golodirsen, and casimersen due to the lack of clarity on viltolarsen’s efficacy and that delandistrogene moxeparovec-rokl’s was

approved outside of their study period.

“We estimated net Medicaid spending by applying the statutory minimum rebate of 23.1% and net Medicare spending by subtracting non-Medicaid rebate estimates from SSR Health, which ranged from 3% to 15%,” the investigators noted. They also gathered data from SSR Health on manufacturer-reported annual US net sales, and projected 2022 spend “assuming that these programs accounted for a similar share of US sales as in 2017 to 2021.”

From 2017 to 2022 alone, there was a 92% jump in estimated US net sales Medicaid and Medicare spend for eteplirsen, golodirsen, and casimersen—\$25 million to \$327 million—which equates to \$1.2 billion. The Medicaid spend far outpaced Medicare: \$1.1 billion (34%) compared with \$104 million (3%). Eighty-two percent of the total US spend was for eteplirsen (\$2.6 billion), followed by 10% for casimersen (\$301 million) and 8% for golodirsen (\$263 million).

These authors underscore how their findings bring attention to the incongruous processes involved in bringing these multimillion-dollar treatments for DMD to market. They highlight that the main controversies in the spend space center on a lack of extensively proven efficacy and delayed confirmatory trials, even with these genetically targeted treatments all having novel mechanisms of action.

They are calling for policy reforms that spur timely trial completion and minimize financial risk when treatments are ultimately deemed nonbeneficial, capping reimbursements to Medicare and Medicaid in instances of accelerated approvals, and alternative payment models for cell and gene therapies. ■

REFERENCE

Bendicksen L, Kesselheim AS, Rome BN. Spending on targeted therapies for Duchenne muscular dystrophy. *JAMA*. Published online March 11, 2024. doi:10.1001/jama.2024.2776

Reducing Low-Value Care Is Hard, but What About Just Not Paying for It?

By Christina Mattina

For the past 2 decades, health economists and managed care researchers—including those with the University of Michigan's Center for Value-Based Insurance Design (V-BID) and the ABIM Foundation's Choosing Wisely initiative—have studied the scourge of low-value care (LVC), or care that doesn't benefit patients and often harms them. Efforts to curb the delivery of such care have yielded mixed results, so panelists at the 2024 V-BID Summit asked a different question: What if we just stopped paying for LVC?

Michael E. Chernew, PhD, director at the Healthcare Markets and Regulation Lab of Harvard Medical School and co-editor in chief of *The American Journal of Managed Care*, started the session with a big-picture look at 3 important questions.

How much LVC is there? As illustrated by Choosing Wisely investigations, perhaps 10% of care is low value, but Chernew pinpointed about 2% as feasible to target.

How do we get rid of it? Financial incentives to patients have inherent difficulties, practitioner behavior is tough to change due to ingrained cultural norms, and the successful initiatives to get a group of organizations on the same page are more the exception than the rule, Chernew said.

Since some LVC will remain, who will pay for it? Possible answers include health care providers, by not getting reimbursed when they order or perform LVC services; health insurance carriers, who would bear the financial risk of LVC; or the end payers (employers, workers, and taxpayers), who would need to eat that cost. The last option has been the status quo, which Chernew called "problematic" in allowing LVC to persist.

A new approach is to implement performance guarantees in the contracts between carriers and payers that specify payers will not pay for LVC. There has been pushback from carriers on this idea and skepticism from those who say the potential savings would be too small, but "if we throw out all the ideas where you're only going to save half a percent or a quarter of a percent, you're going to have no ideas," Chernew said. He also mentioned that these performance guarantees could be titrated to address concerns about imperfection in measurement.

Providing a real-world example of this strategy was Joshua Fangmeier, MPP, assistant director for plan strategy at Minnesota Management and Budget. His state is a large self-insured employer that has tried to use tools aligning with VBID principles to improve outcomes and save costs. A reduction in cost sharing for high-value diabetes care was successful in boosting utilization, but targeting LVC through benefit design is more challenging due to the need for nuance. To really effect change in the LVC rates, the state turned to a collaboration with its third-party administrator, which handles the day-to-day claims processing, rate negotiation, medical policy, network management, and customer service aspects of the health benefit.

When creating its request for proposal for the administrator last year, Minnesota added performance guarantees that aimed to develop accountability

around LVC, focusing on 3 measures: unnecessary imaging for low-back pain, low-value vitamin D screening, and low-value testing and laboratory work prior to low-risk surgery.¹ The first year of the contract will be used to inform a benchmark for future years, then the administrator's revenue will be put at risk if the specified thresholds are not met. Fangmeier added that they are excited to see how these guarantees impact not

just the specified services but also the cascades of care they spark, which can incur huge costs for both the plan and members' out-of-pocket costs.

"When you look at just the dollars associated with just the [LVC] services, it might be half a percent or maybe 1% of total costs are likely [LVC]," he said, "but thinking through, it's not just the service itself, but the other care that can be set off from that service."

Chernew called this work a model of "sensible" steps that others can adapt—and cautioned that payers who don't are leaving money on the table.

"The key point is the if you put this in a performance guarantee, these are guaranteed savings and you get a [return on invest-

ment]—depending on how aggressive you want to be—of multiples, right? This is simply, 'We're just not going to pay for things we shouldn't pay for.' That's easy money."

Both panelists agreed that there's no one-size-fits-all language to place in every contract, so employers interested in

“When you look at just the dollars associated with just the [LVC] services, it might be half a percent or maybe 1% of total costs are likely [LVC]...”

this approach will need to work with an employee benefits consultant who is aligned on their goals and willing to think outside of the box.

It would be much more challenging for fee-for-service Medicare to adopt performance guarantees due to federal rules and regulations, Chernew said, but the mechanisms of Medicare Advantage plans do push the risk onto carriers, and some evidence shows that accountable care organization programs' efforts to resist paying for LVC are having the intended effect.²

Headwinds for employers may encourage them to take a harder line on LVC out of necessity, Fangmeier said, as they face the impacts of the postpandemic rebound in care, the high costs of breakthrough drugs, and the large population of members eligible for glucagon-like peptide-1 receptor agonists. These spending drivers will spur many to look for "opportunities to tackle things that do not hurt employees or their family members in terms of their financial bottom line."

Tying together the themes of the summit in his closing remarks, Chernew said that "employers are facing this trade-off. We're either going to charge people more out of pocket, shift costs to them, create barriers to accessing all of these needed services, or we're going to find some other way to control spending." ■

REFERENCES

1. Request for proposal: plan administration for the Minnesota Advantage Health Plan. Minnesota Management and Budget. February 13, 2023. Accessed March 14, 2024. <https://mn.gov/mmb-stat/segip/2023-medical-plan-admin-rfp-operational-pgs.pdf>
2. Schwartz AL, Chernew ME, Landon BE, McWilliams JM. Changes in low-value services in year 1 of the Medicare Pioneer accountable care organization program. *JAMA Intern Med.* 2015;175(11):1815-1825. doi:10.1001/jamainternmed.2015.4525

Fragmented Payer System, Vulnerable Supply Chain Among Threats to Accessing Essential Medicines

By Christina Mattina

The barriers standing between patients and the prescription medications they need extend far beyond the pharmacy counter, according to panelists who spoke at a 2024 V-BID Summit session Wednesday. The session, "Enhancing Access to Essential Medications," fit into the summit's theme of "Overcoming Financial Toxicity," which is a particular focus for the University of Michigan Center for Value-Based Insurance Design (V-BID Center).

Stacie Dusetzina, PhD, professor of Health Policy and Ingram Professor of Cancer Research at the Vanderbilt School of Medicine Department of Health Policy, and Inma Hernandez, PharmD, PhD, professor at the University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences, approached the threats to medication access from different angles. Both Dusetzina and Hernandez are members of the editorial board of *The American Journal of Managed Care*.

Dusetzina, whose research focuses on insurance design and the impacts of drug costs, began by dividing her thoughts on drug access into 2 categories: the common prescriptions like insulin, inhalers, and blood thinners that are used by millions of patients on a chronic basis, and the big-budget items such as cell and gene therapies or glucagon-like peptide-1 (GLP-1) receptor agonists that are causing financial pressure across the health system.

Access is mediated by insurance, Dusetzina explained, and because Medicaid is required to cover FDA-approved drugs with low cost sharing, her remarks focused on the challenge of commercial and Medicare insurance. Deductibles and coinsurance are key barriers to accessing chronic disease medications, and the unpredictability of these costs month to month can make it hard for patients to

budget. Some recent bright spots include the \$35 caps on insulin adopted by Medicare and some states, the Inflation Reduction Act (IRA) provision specifying no cost sharing for vaccines under Part B, and the IRA's establishment of month-to-month payment smoothing and a \$2000 annual out-of-pocket maximum. Employers are also starting to be more creative with covering some high-value therapies on a preeductible basis, Dusetzina noted.

On the other hand, new high-cost drugs such as cell and gene therapies and CRISPR-based technologies are putting immense pressure on the system to afford their price tags of millions of dollars per patient treated. Less costly individually but applying to a huge population of eligible recipients, GLP-1 drugs are also threatening to hike costs that will get passed along to the employer, patient, and taxpayer. The Center for Medicare and Medicaid Innovation is trying to create outcomes-based agreements for these costly therapies, Dusetzina said, but there is a long road ahead.

Moderator Cliff Goodman, PhD, senior vice president at the Lewin Group, noted new therapies for Alzheimer disease as another emerging therapeutic category with a massive eligible population that could threaten to break the system. The principles of VBID will need to be applied to each drug and its clinical benefits to establish which are worth paying for when considering their potential to reduce downstream spending, Dusetzina explained, before proposing a different way of thinking about how to balance budgets to enable access to transformative therapies.

"We'd have to really be creative about how exactly do we pay for it and where do we invest in more of a single-payer type of strategy or negotiation, thinking a little bit like how we handled COVID-19 vaccines

and treatments, as when we have such innovative treatments that are real breakthroughs for people, should we think about those not as this fragmented set of payers but in a more coordinated way?”

Next, Hernandez, whose work focuses on pharmaceutical access, reminded listeners that barriers to access are not always related to insurance coverage. For instance, generic drugs are reimbursed by pharmacy benefit managers at markups exceeding 1000% in some cases, and because these reimbursement rates are the basis for patient cost sharing, patients are paying an inflated amount for generic drugs through their insurance that often exceeds what they would pay via cash. This paradox has led to the popularity of direct-to-consumer options like the Mark Cuban Cost Plus Drug Company, leaving the current system of pharmacy benefits ripe for reform.

A second threat to access is the nation's vulnerable drug supply chain, which is enduring a record high number of drug shortages. The problem is exacerbated for generics because they compete only on price, Hernandez said, and this pricing pressure means manufacturers can't raise prices when production costs increase. Congressional hearings have discussed value-based reimbursement as a solution, in which providers would be paid more for selecting generics coming from more resilient supply chains.

Resiliency is also being put to the test in cybersecurity, as evidenced by the crippling effects of the Change Healthcare outage on claims processing and reimbursement.¹ Pharmacies are dispensing drugs with the plan to submit claims once the system is restored, so the attack hasn't affected patient care, but we may not be so lucky next time. Other countries have

seen drug wholesalers attacked, Hernandez noted, which could be catastrophic in the US where just 3 wholesalers dominate the market.

Finally, a serious threat to medication access is the creation of pharmacy deserts as independent pharmacies are forced to shut their doors. With direct-to-consumer options like Cost Plus Drug meeting more of the demand for generics and mail-order pharmacies providing more specialty drugs, Hernandez wondered how small, local pharmacies will be able to stay open to deliver essential services like giving vaccines.

“This is just a sample of some new and some prevalent issues that threaten patient access to important medications beyond prices and some issues that, in my opinion, are also prime for policy reform,” Hernandez concluded.

Goodman then asked the panelists for their input on why prescription drugs often cost more in the US than other countries. The fragmentation of the US health system into individual state Medicaid programs, federal Medicare, and commercial payers means that no one player has as much leverage in negotiations, Dusetzina said, and there is not as much political will to take the risk of curtailing treatment choices if their manufacturers will not negotiate their prices. The IRA's drug price negotiation effort may be able to illustrate the effect of negotiation in the US—if it can survive a gauntlet of legal challenges and the fate of the presidential election in November.

Another challenge is that serious considerations around equity need to be included in efforts to ensure access to cutting-edge drugs, with Hernandez noting the potential for disparities to be exacerbated by lack of insurance coverage. She worried that the stigma of obesity has driven the decision not to

cover the GLP-1s despite their impressive therapeutic profile.

“We cannot pretend to be serious about health equity and not have these conversations around coverage of these drugs that are indicated for diseases that have a disproportionate burden for underrepresented minorities and underserved populations,” Hernandez said.

She added that the FDA's approval of an expanded indication for semaglutide (Wegovy) to prevent cardiovascular events² should help to encourage wider coverage, so if she had carte blanche to pull one policy lever that would expand access, she would instead choose pharmacy benefit manager reform to improve transparency.

In keeping with the mission of the summit's host, Dusetzina's wish-list item would be the incorporation of more VBID principles so that coverage and cost sharing would be based on a treatment's value.

“That means really focusing a lot on low-value treatments and making those less accessible, less likely to be covered. Stop spending so much money there, and spend more money on the things that really benefit patients and get the outcomes that we want.” ■

REFERENCES

1. AJMC Staff. What we're reading: crackdown on counterfeit Ozempic; ALS drug fails in clinical trial; cyberattack profit losses. AJMC. March 11, 2024. Accessed March 13, 2024. <https://www.ajmc.com/view/what-we-re-reading-crackdown-on-counterfeit-ozempicals-drug-fails-in-clinical-trial-cyberattack-profit-losses>
2. Mattina C. FDA approves semaglutide to prevent heart events in patients with CVD and excess weight. AJMC. March 8, 2024. Accessed March 13, 2024. <https://www.ajmc.com/view/fda-approves-semaglutide-to-prevent-heart-events-in-patients-with-cvd-and-excess-weight>

Study: ACA Medicaid Expansions Increased Coverage for Childbearing Age American Indian, Alaska Native Women

By Brooke McCormick

The Affordable Care Act (ACA) Medicaid expansions increased coverage for American Indian/Alaska Native (AI/AN) women of childbearing age, according to a study published in *Health Affairs*.

Compared to national averages, the researchers explained that AI/AN women face elevated rates of uninsurance, poverty, poor birth outcomes, and chronic diseases, particularly hypertension and diabetes. Enacted in 41 states from 2014 through 2023, the US government attempted to increase health coverage for women with incomes up to 138% of the federal poverty level, regardless of pregnancy, through the ACA Medicaid expansions.

Despite its potential benefits, barriers like health care professional shortages, underfunding of the Indian Health Service (IHS), and discrimination in health care settings impacted the effectiveness of the expansions on AI/AN women of childbearing age. Although they increased insurance coverage among low-income patients, most studies found that the Medicaid expansions did not improve early prenatal care, preconception health conditions, or birth outcomes.

To build on these findings, the researchers created a difference-in-differences study design to compare health care usage and health outcomes among AI/AN women between the ages of 19 and 45 before and after Medicaid expansions; they paid special attention to where they live, comparing the impact of Medicaid expansions on women living in areas with relatively high percentages of reservation land and on women living in metro areas.

The researchers used data from the 2010 to 2019 sample of the American Community Survey to study insurance, data from the 2010 to 2019 Natality All-Counties Files to study maternal and infant health, and county-level data from the 2010 to 2019 Area Health Resources Files to describe health care supply.

Through the American Community Survey sample, the researchers determined that, before Medicaid expansions, AI/AN women had an uninsured rate of 24.5%, 26.6% reported only having Medicaid, 10.4% reported only using the IHS, and 7% reported having Medicaid in combination with the IHS. On the other hand, within the Natality sample, 64.1% of AI/AN mothers reported having prenatal care in the first trimester, 6.2% of births weighed less than 2500 grams, and 3.5% were diagnosed with hypertension or diabetes before pregnancy.

Providers, to be strikingly lower in AI/AN counties before Medicaid expansions. Provider density did not change after the expansions, with both AI/AN counties and comparison counties in non-expansion states having lower densities of physicians in comparison to those in expansion states.

The researchers acknowledged their study's limitations, one being that their data had limited sample sizes in select state-year cells due to the small AI/AN populations in some states. Also, the available data did not provide direct measures

Compared to national averages, the researchers explained that AI/AN women face elevated rates of uninsurance, poverty, poor birth outcomes, and chronic diseases, particularly hypertension and diabetes.

After Medicare expansions, the researchers found the proportion of AI/AN women reporting health care coverage from both Medicaid and the IHS increased, with a larger impact on those living in areas with relatively high percentages of reservation land. More specifically, they associated the expansions with a 7.9% increase in Medicaid coverage, a 3.9% reduction in uninsurance, and a 3.8% decline in coverage by private insurance only.

Additionally, the Medicaid expansions did not impact first-trimester prenatal care usage or birthweight among AI/AN women. Conversely, they found diagnoses of prepregnancy diabetes or hypertension increased by 0.58% after the expansions, particularly in women living in areas with more reservation land.

Lastly, in terms of health care supply, the researchers reported the density of physicians, especially specialty physi-

of women's connections to tribal communities or usage of tribal or IHS services. Despite these limitations, the researchers highlighted areas of future improvement to benefit AI/AN women based on their findings.

"Although state Medicaid expansions had positive effects on AI/AN women's insurance coverage, policy makers seeking to improve AI/AN health should take a more comprehensive approach to improving social and environmental determinants of health and building on cultural and local resources," the authors concluded. ■

REFERENCE

Strully KW, Chatterji P, Liu H, Han S, Schell L. Effects of Medicaid expansions on coverage, prenatal care, and health among American Indian/Alaska Native women. *Health Affairs*. 2024;43(3):344-353. doi:10.1377/hlthaff.2023.00672

Patients on Medicare Advantage Receive Shorter, Less Intensive Home Health Care

By Julia Bonavitacola

Patient outcomes when using home health care services were different depending on whether the patient used Medicare Advantage (MA) or traditional Medicare (TM), according to a study published in JAMA Health Forum. The study found that this extended to patients who had similar needs from their health services.

Patients who are homebound and on Medicare can request home health care services as long as their clinician identifies the need, which includes rehabilitation, home health aides, and nursing. MA plans are being used by private insurers to provide these home health care services, with the enrollment in MA surpassing that of TM. Patients on TM are certified for 60-day home health episodes but patients on MA have shorter home health stays. Patients with MA can also receive care from lower-quality agencies. Administrative data from a national health care network was used for this study to evaluate the gaps in care between TM and MA when it came to home health care.

Data from 102 locations in 19 states were collected from a national nonprofit home health company. Data from January 2019 through December 2022 about admission and discharge assessments were used. Patients who were aged 65 years and older and had 2 or fewer 60-day certification episodes

were considered for this study. Patients seen for intermittent maintenance care were excluded.

Length of stay (LOS) and number of visits were used as home health intensity outcomes. LOS was defined as the number of days between the start and discharge of home health. The number of visits could include visits from nursing, physical therapy, speech therapy, home health aides, social work, and occupational therapy. Demographic characteristics were collected from all patients, with race and ethnicity being self-reported. Level of cognitive impairment was included along with whether home health was provided in an institution or a community setting.

There were 178,195 patients with TM and 107,102 patients with MA included in this study. Patients with MA were younger, more likely to identify as male and non-Hispanic White, and were more likely admitted from the hospital compared with patients with TM. Patients on MA were less impaired in self-care and mobility at admission, had lower rates of cognitive impairment, and had lower overall medical risk.

Patients with MA had a 1.62 day (95% CI, -1.82 to -1.42) shorter mean home health LOS. Patients with MA also received 4.9% fewer nursing visits, 2.7% fewer physical therapy visits, 2.9% fewer occupational therapy visits, 5% fewer home health aide visits, and

5.0% fewer speech therapy visits. Mobility function and self-care function were 3% (OR, 0.96; 95% CI, 0.94-0.99) and 4% (OR, 0.97; 95% CI, 0.92-0.99) less likely in patients with MA, respectively. Being discharged to the community was also 5% less likely in patients with MA (OR, 1.05; 95% CI, 1.01-1.08) compared with patients with TM.

There were some limitations to this study. Differences in MA plans were not accounted for in the analysis. Data from inpatient stays were not available. Assessments had the potential to be incomplete. The researchers were unable to link an improvement in function to quality of life or independence. All data came from 1 nonprofit company, which may not make the data generalizable to companies that are for profit.

The researchers concluded that patients on MA had a shorter LOS for home health, had fewer visits by their home health, and had lower rates of improving self-care. Independence and caregiver burden in patients with MA could be influenced by these results. ■

REFERENCE

Prusynski RA, D'Alonzo A, Johnson MP, Mroz TM, Leland NE. Differences in home health services and outcomes between traditional Medicare and Medicare Advantage. JAMA Health Forum. Published online March 1, 2024. doi:10.1001/jamahealthforum.2023.5454