School of Public Health
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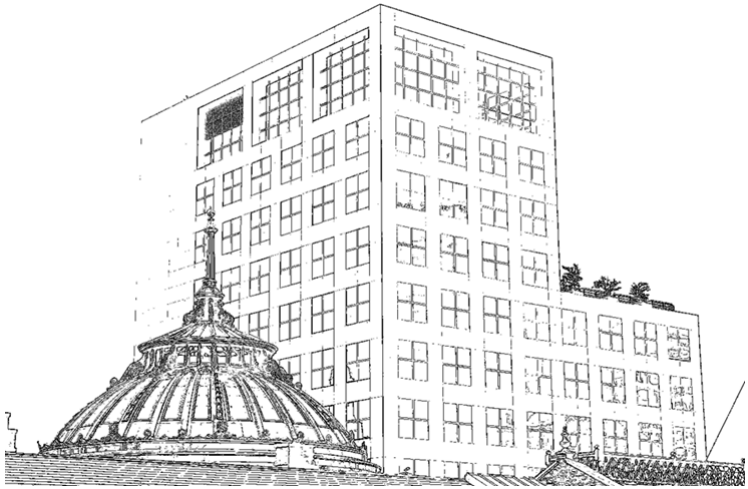
CENTER FOR ADVANCING
HEALTH POLICY
THROUGH RESEARCH



UPCOMING EVENTS

WEBINAR

Medicare Advantage Payment and Opportunities for Cost Containment

- **Date:** Friday, May 2nd
- **Time:** 12:00 pm ET
- **Location:** Virtual via Zoom

Learn more and register

PANEL EVENT

Higher Costs, Less Competition: The Rise of Vertical Integration in the U.S. Health Care

System

- **Date:** Wednesday, May 7th
- **Time:** 12:30 PM - 2:30 PM ET
- **Location:** Washington, D.C.

Learn more

MEDICARE ADVANTAGE

The Effect of Extending the Window to Disenroll From Medicare Advantage Among Post-Acute Users

After CMS extended the Medicare Advantage (MA) disenrollment window in 2019, this study published in *Medical Care Research and Review* assessed whether post-acute care users were more likely to switch plans. Using Medicare data from 2016–2019, the researchers focused on individuals recently discharged to skilled nursing

facilities or home health care—groups that often encounter access issues under MA plans. The study findings found no change in overall disenrollment, but a small increase in switching between MA plans, especially among those using home health services. However, such switching remained rare. The findings suggest that even with more flexibility, barriers to exiting or switching plans remain for vulnerable patients.

Racial Disparities in End-of-Life Home Health Use in Medicare Advantage vs Traditional Medicare

This research letter published in *JAMA* finds that MA enrollees received less end-of-life home health care than those in Traditional Medicare (TM)—especially among racially and ethnically minoritized groups. For example, Hispanic descendants used home health care 11 percentage points less in MA than in TM. Overall, MA enrollees received 4.2% fewer home health

services in their last year of life. The findings raise concerns about access barriers in MA plans, including network restrictions and prior authorization policies.

Examining Trends in Medicare Advantage Plan Disenrollment Associated With Expanded Supplemental Benefit Adoption

This *Health Services Research* study analyzed whether offering new supplemental benefits—like caregiver support, transportation, and food assistance—reduced disenrollment from MA plans. Using national data from 2017–2021, the authors find that the adoption of these benefits did not significantly affect disenrollment rates for either dual-eligible or Medicare-only enrollees. Despite hopes that such benefits would help MA plans retain medically and socially complex members, the study suggests these offerings may not influence plan-switching behavior.

Enhanced COVID-19 Provider Relief, Hospital Finances, and Care for Medicare Inpatients

This study published in *JAMA Health Forum* examines whether hospitals that received enhanced COVID-19 relief funds (about $100,000 per bed) had different financial or care outcomes than those receiving only basic relief (about $45,000 per bed). Among 555 hospitals near funding thresholds, those with enhanced aid saw slightly improved margins (+1.4 percentage points) and more stable liquidity, but no significant changes in Medicare inpatient volume, complexity, mortality, or use of high-resource services. The findings suggest enhanced funds helped stabilize finances but did not expand care capacity or alter service delivery. The author calls for more targeted, outcome-linked relief strategies in future crises.

Participation and Attrition in the Medicare Shared Savings Program

This *Health Affairs Scholar* study analyzes trends in participation and dropout rates in the Medicare Shared Savings Program, that relies on Accountable Care Organizations (ACOs) to manage care and reduce costs. From 2012 to 2024, ACO participation initially rose but plateaued after 2018, while clinician participation grew to over 650,000 by 2021. Yet attrition was substantial: only 55% of ACOs stayed in the program for more than six years, and clinicians remained for an average of just 3.6 years, with a 16% annual exit rate. The authors suggest that financial incentives—especially following policy changes that made savings targets harder to meet—may not be strong enough to sustain participation. High turnover threatens the program's ability to drive long-term care transformation, underscoring the need for more

robust incentives and support to maintain engagement in voluntary value-based care models.

PRIVATE EQUITY IN HEALTH CARE

Private Equity–Owned Physician Practices Decreased Access to Retinal Detachment Surgery, 2014–22

This *Health Affairs* study finds that PE-acquired practices reduced provision of retinal detachment repairs by 19.6% relative to matched controls post-acquisition.This decrease likely reflects PE firms' focus on short-term profitability, leading to reduced access to costly, time-sensitive services, especially for Medicare patients where reimbursement is below cost. The findings raise concerns that PE ownership may limit access to essential, unprofitable services—particularly affecting older and medically complex patients.

Private Equity Acquisitions and Industry Payments in Ophthalmology

This *JAMA Ophthalmology* study investigates whether PE acquisitions affect the financial interactions between ophthalmologists and the healthcare industry, such as pharmaceutical or medical device firms. The study found that before being acquired, PE-affiliated ophthalmologists received more and higher industry payments than their peers. After acquisition, the total amount of these payments dropped by 18%, but there was no significant change in the number of payments. This suggests that PE ownership may reduce financial ties with industries that don't directly support the practice's financial goals, which could affect doctors' clinical decisions.

**"industry payments" include things like consulting fees, speaking honoraria, and sponsored meals — not research payments*

Increases In Physician Professional Fees In Private Equity–Owned Gastroenterology Practices

In this *Health Affairs* study, authors examined how PE acquisitions affect pricing in gastroenterology practices compared to both health system–affiliated and independent practices. After PE acquisition, prices rose by $92 per claim (a 28.4% increase), driven primarily by a 78.1% rise in physician professional fees, while facility fees remained largely unchanged. Utilization of services also increased. These findings suggest that PE firms may boost revenue mainly by raising professional fees, potentially offsetting the cost-saving goals of shifting care away from expensive hospital settings to outpatient clinics.

Physician Turnover Increased In Private Equity–Acquired Physician Practices

This study published in *Health Affairs*, looks at how PE acquisitions affect physician employment, focusing on turnover and workforce composition. The authors found that physician turnover increased by 13 percentage points (a 265% rise) after PE acquisition. At the same time, practice size grew by 46.8%, with increases in both ophthalmologists and optometrists. PE-acquired practices also had higher clinician replacement ratios than non-PE counterparts, indicating more frequent staff changes. While PE ownership may lead to growth and expansion, it also appears to create more dynamic but potentially less stable work environments, raising concerns about care continuity and physician satisfaction.

Private Equity Acquisitions of Radiology Practices From 2013 to 2023: National- and State-Level Analyses

The *American Journal of Roentgenology* study analyzes PE acquisitions of U.S. radiology

practices from 2013 to 2023, finding that PE ownership grew rapidly, with 12% of all radiologists working in PE-owned practices by 2023—up from just 1% in 2013. Concentration was especially high in states like Nevada and Arizona, and three large firms dominated the market. The highest concentrations were in Nevada (47%) and Arizona (44%), with Radiology Partners, LucidHealth, and U.S. Radiology Specialists accounting for the vast majority of PE-employed radiologists. The authors call for further research into how PE ownership may affect patient access, imaging use, and the radiology workforce.

The Rise of Private Equity in Health Care — Not a Uniquely American Phenomenon

In this *New England Journal of Medicine* Perspective piece, authors explore the global expansion of private equity in health care where between 2018 and 2022, PE firms invested $446 billion in health care globally, with activity

spreading across high-income countries such as the UK, Canada, Germany, Sweden, France, and Australia. They find that PE firms tend to target sectors with limited public regulation and fragmented services, such as outpatient care, dental clinics, and long-term care and highlight common concerns across countries, including lack of ownership transparency, reduced competition, workforce strain, and the financialization of care.

MARKET CONSOLIDATION & PRICE DYNAMICS

New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality

This *Health Services Research* study finds that cross-market hospital mergers lead to significant price increases—12.9% on average and 16.3% for serial acquirers—without improving care quality.

Prices rose regardless of whether mergers were in-state or out-of-state and were higher when the acquired hospital had greater market share. The authors call for more antitrust oversight, noting that these mergers raise costs without delivering better outcomes.

Understanding health care price variation: evidence from Transparency-in-Coverage data

This *Health Affairs Scholar* study uses Transparency-in-Coverage (TiC) data to assess commercial healthcare pricing across U.S. insurers and states. The authors find substantial price variation for common services both within and across insurers. For instance, the price of a foot X-ray ranges from $86 (Anthem) to $190 (UnitedHealth). Even within the same insurer, prices for inpatient care and outpatient care often don't follow any clear pattern—high prices in one area don't predict high prices in the other. This

shows that healthcare prices in the U.S. are highly inconsistent and unpredictable, making it harder for patients to shop around and for employers and policymakers to control costs.

Commercial Prices and Care for Medicare Beneficiaries With Prostate Cancer

This *Health Services Research* study examines how commercial prices paid to urologists influence Medicare spending for men with newly diagnosed prostate cancer. The study finds that in areas where commercial payments are higher — Medicare spending is actually lower by about $1,485 per patient. This is driven by fewer patients receiving treatment overall and a shift toward surgery rather than radiation (surgery provides higher reimbursement to urologists). These findings also support the target income hypothesis: physicians earning more from commercial insurers may limit care for Medicare patients. The authors emphasize the need for

stronger price transparency, regulatory oversight, and antitrust enforcement to address growing price variation and market consolidation.

State-Level Hospital Quality in the United States: Analyzing Variation and Trends From 2013 to 2021

This *Journal for Healthcare Quality* study develops a hospital quality index to analyze state-level variations in hospital quality in the United States from 2013 to 2021, using data from 3,000 hospitals from the Centers for Medicare & Medicaid Services (CMS) Hospital Compare data set. Eight states performed significantly better than the national average, with Utah leading at 0.56 standard deviations above the U.S. average, followed by Hawaii (0.47), South Dakota (0.44), and Oregon (0.42). Conversely, 14 states performed significantly worse than the U.S. average, with Nevada (−0.51), West Virginia (−0.45), Florida (−0.44), and Arkansas (−0.38)

performing the worst. The quality index provides a valuable tool for understanding and addressing variations in hospital care quality.

POLICY & STRUCTURAL REFORM

Reviving public provisioning in US health care

This *Health Affairs Scholar* commentary advocates for reviving public ownership and delivery in U.S. health care as a response to increasing corporate consolidation and financialization. It highlights the critical role of public hospitals, health districts, publicly affiliated clinics, and state-run pharmaceutical programs in providing high-quality care, especially in underserved communities. Despite their value, these models face significant barriers due to policy restrictions and underfunding. The authors call for a new industrial policy to expand public provisioning,

strengthen care infrastructure, and ensure that public investments serve broader societal goals.

A New Medicare Agenda—Moving Beyond Value-Based Payment and the Managed Care Paradigm

This viewpoint published in *JAMA* argues that value-based payment —the dominant Medicare reform model—has failed to reduce costs and has added corporate intermediaries without improving care. The authors criticize this model for burdening clinicians with insurance functions and overlooking the real cost drivers: high prices, expensive technology, and administrative waste. They propose a new agenda that shifts away from total-cost-of-care models toward a reformed fee-for-service Medicare that includes — more rigorous pricing of new technologies (e.g., through value-based coverage), capping out-of-pocket costs, adding benefits like dental and vision, adjusting physician payments to support

primary care, and eliminating incentives that push providers into risk-bearing contracts.

Flaws in the Medicare Advantage Star Ratings

This viewpoint published in *JAMA Health Forum* critiques the MA star ratings system, which influences over $10 billion in annual bonus payments. The authors argue the system is flawed: beneficiaries often don't use the ratings, the measures can be manipulated by plans, and they don't reflect care quality for vulnerable populations. They propose several reforms—like focusing on outcomes that matter to patients, adjusting ratings for social risk factors to better reflect plan performance across diverse populations, recalibrating the distribution of ratings so that high-performing and low-performing plans are more clearly distinguished, stratifying ratings by subgroups, such as those with high medical needs, and making the program

budget-neutral to reduce excessive bonus payments with limited value.

TESTIMONIES & BRIEFINGS

HOSPITAL PAYMENT CAPS AND SPENDING

Roslyn C. Murray, PhD

> Nevada State Assembly, Health and Human Services Committee - Testimony on the impact of hospital payment caps on prices and spending – March 11, 2025
>
> Colorado General Assembly - Comments on hospital payment caps impact on prices and spending - February 26, 2025.
>
> New York State Legislative Briefing - Legislative briefing on New York's Fair Pricing Act and the estimated savings attached to its implementation - February 11, 2025

> Washington State Legislature, House Appropriations Committee - Testimony on the impact of hospital payment caps on prices and spending- January 28, 2025

Christopher Whaley, PhD

> Montana State Legislature, Senate Public Health, Welfare and Safety Committee - Testimony on the impact of hospital payment caps on prices and spending - March 31, 2025

NOTABLE POLICY COMMENTARIES

> The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices - Milbank Memorial Fund
>
> "All I Do Is Win": Why Beating Benchmarks Doesn't Mean That ACOs Are Reducing Costs

- Health Affairs Forefront

Private Equity's Impact On Medical Trainees - Health Affairs Forefront

Can Public Option Plans Improve Affordability? Insights From Colorado - Health Affairs Forefront

Congress Can Unlock The Full Potential Of Telehealth Through A Permanent Fix - Health Affairs Forefront

Ensuring Access, Affordability, and Quality in the Age of Healthcare Consolidation: Lessons Learned and Insights for the Future - The Aspen Institute

MEDIA MENTIONS

New Medicare telehealth data drops as industry waits on Congress - STAT News

States consider raising health premiums for their employees - AXIOS

The Danger of Trump's Deregulation Play - MedPage Today

NY hospital prices four times higher than doctor's offices, report finds - Times Union

Indiana Governor Appoints Business Leader To Shake Up Health Care - KFF

Nearly half of buyers on individual market picked Colorado Option health plans for 2025 - Denver Post

Hospitals cry foul as public option enrollment rises- Modern Healthcare

Colorado hits record for health marketplace signup, though federal uncertainty is on the horizon- Colorado Public Radio

> Bill would limit hospital fees in Nevada's public employee health system - Las Vegas Review-Journal
>
> With threats of doom on both sides, legislators advance bill to cap hospital prices - The Sum and Substance Colorado

PODCASTS

> Who Employs Your Doctor? - Humans in Public Health Podcast
>
> Podcast: LIVE with Yashaswini Singh on Private Equity's Effect on Health Care Staff Turnover - A Health Podyssey
>
> Interview with Yashaswini Singh on the expansion of private equity investments in health care and actions to safeguard patient interests in various countries - The New England Journal of Medicine

GRANTS & AWARDS

THE IMPACT OF EXTREME WEATHER EVENTS ON HEALTHCARE

Dr. Christopher Whaley has been awarded a CHAIRS-C pilot grant to study the impact of extreme weather events on forgone healthcare among the elderly. The project will link Medicare claims data (2007–2024) with data on hurricanes, floods, and extreme heat to analyze how these climate-driven disasters affect essential care use, medication adherence, and health outcomes in older adults with chronic conditions.

CAHPR is an evidence-based, nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in

healthcare delivery in the US. Learn more about us at https://cahpr.sph.brown.edu/.

If you have questions about our research, would like to request briefs and reports, or engage with the center's investigators, please contact Jared Perkins, Director of Health Policy Strategy, at jared_perkins@brown.edu.