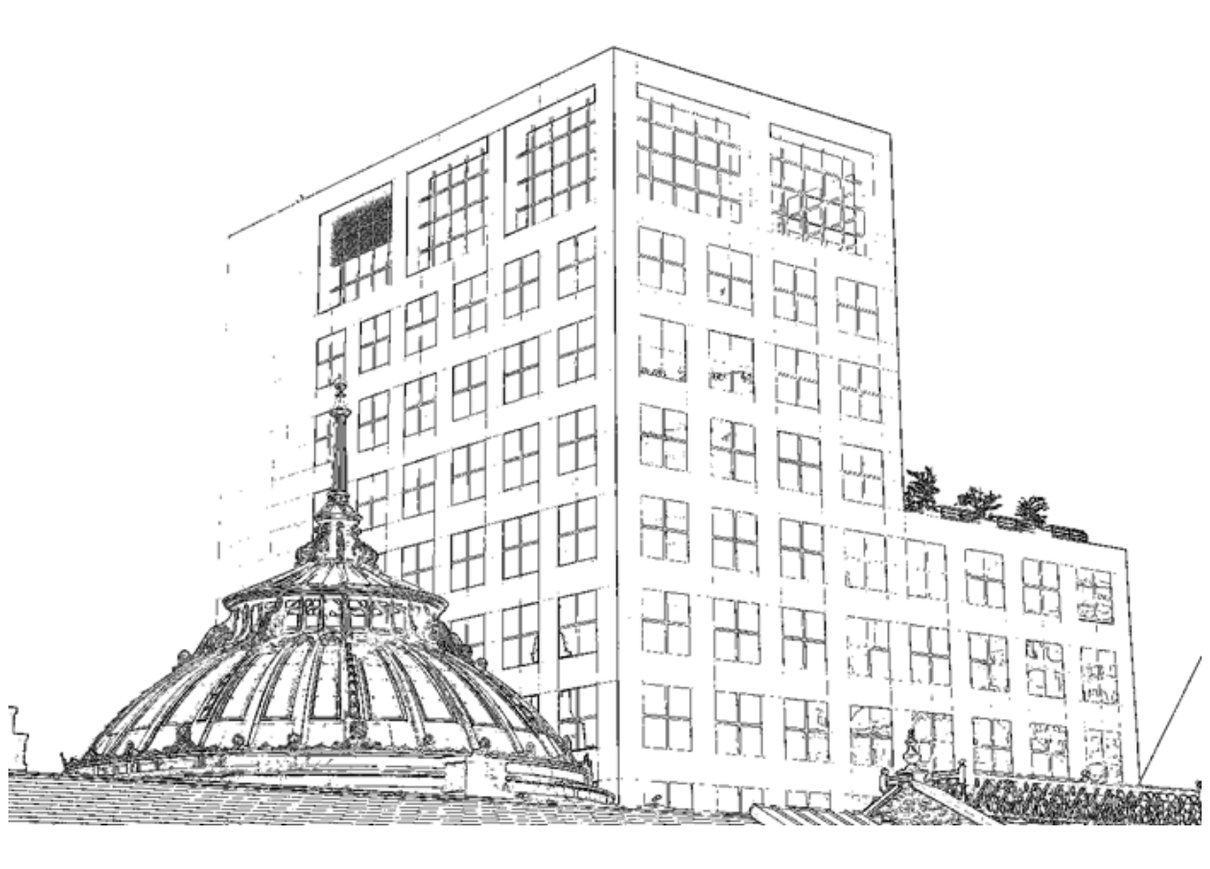
School of Public Health
BROWN UNIVERSITY

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH



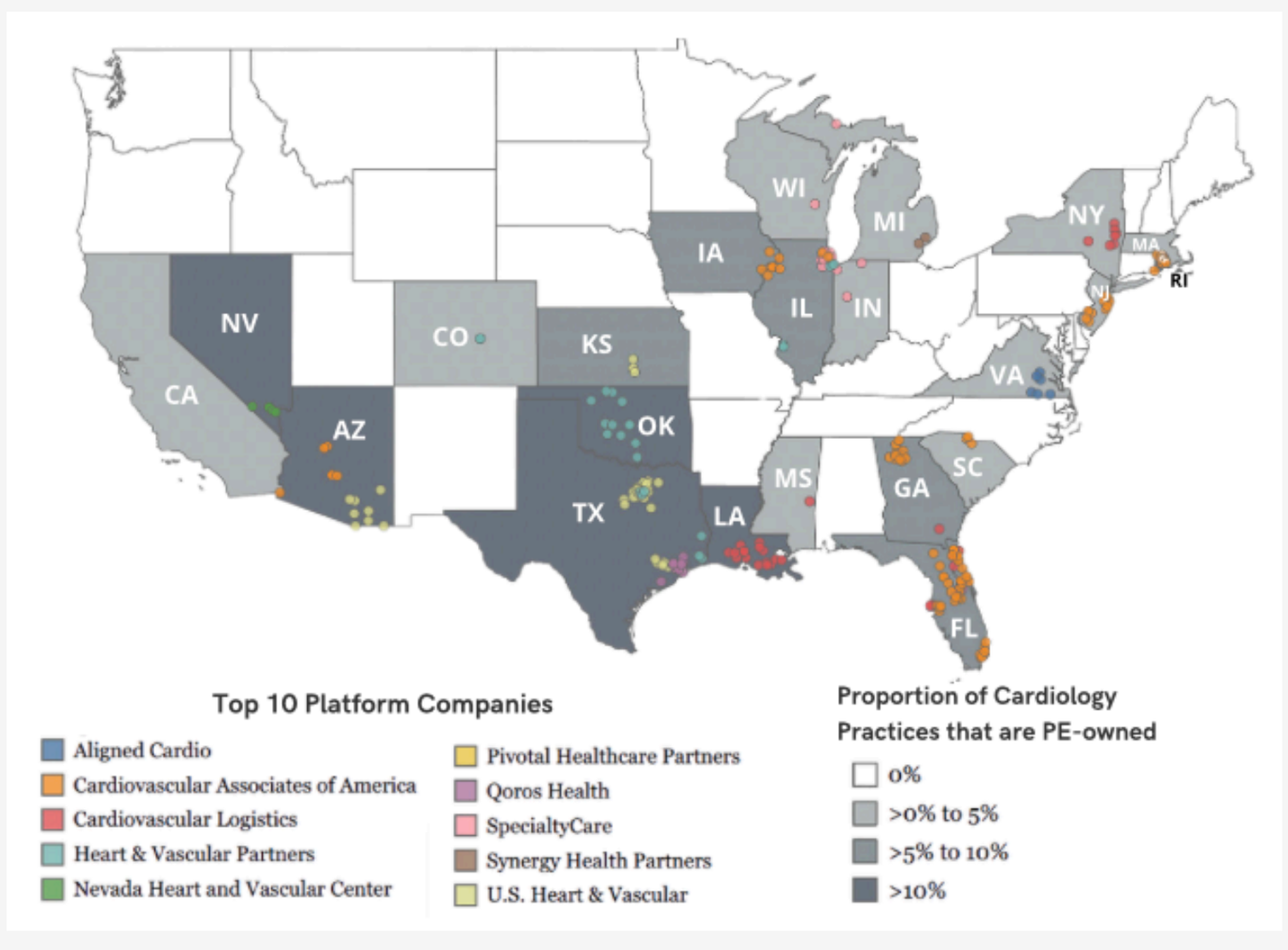
RESEARCH HIGHLIGHT OF THE QUARTER

Private Equity now represents approximately 4% of all cardiology practices in the US.

Private equity (PE) interest in cardiology practices is growing, driven by rising cardiac disease rates, sector fragmentation, and attractive payment incentives. In a study published in *JAMA Health Forum*, CAHPR investigators analyzed PE consolidation of cardiology practices, from 2019 (having 1 deal with 7 locations) to 2023 (having 50 deals with 320 locations) and found that:

- PE-acquired cardiology practices have a **higher presence in states like Florida, Texas, and Arizona.**
- Major platform companies like **Cardiovascular Associates of America and US Heart & Vascular operated over 60% of cardiology practices** in Florida, Georgia, and Texas.

The study raises questions on PE's impact on competition, pricing, and healthcare access in cardiology while emphasizing the need for ongoing scrutiny to guide policy and regulatory responses.



Related Work:

- Response to DOJ/FTC/HHS RFI on Health Care Consolidation | CAHPR RFI
- Policy Options to Address the Growth of Private Equity Among U.S. Physician Practices | CAHPR Policy brief

HEALTH CARE MARKETS

Healthcare's New Wave of Consolidation: Insurer-Provider Integrations.

A study published in *Health Affairs Scholar* examined the rise of insurer–provider integration, focusing on UnitedHealthcare's (UHC) acquisitions of ambulatory surgery centers (ASCs). It found that **UHC owns ASCs in 147 counties across 35 states**, with significant market concentrations in Indiana, California, and Florida. Moreover, these ASC acquisitions are concentrated in areas where UHC has a strong insurance market share. Despite potential benefits like better care coordination, the study cautions about higher costs and increased market concentration, urging regulators to monitor this trend closely.

Related Work: Medicare Advantage and Consolidation's New Frontier—The Danger of UnitedHealthcare for All - The New England Journal of Medicine

Hospital behavior over the private equity life cycle.

A study published in *The Journal of Health Economics* analyzed the behavior of HCA after it was PE-acquired in 2006 and found:

- A **strategic increase in advertising expenditures** with outdoor advertising surging to over $1 million per quarter,
- **Hospital expansion into ambulatory surgery centers (ASCs)** to diversify revenue streams and capture outpatient surgical referrals,
- **Increased inpatient admissions** by 12% after acquisition, including a rise in emergency room admissions,
- **Lowered intensity of care** and length of hospital stay, with a 30-40% rise in same-day discharges and with a 5-10% decrease in in-patient mortality,
- **Reduced outpatient surgery volume** by 18- 21%, although assessed cases were more complex.
- **Shifted payer mix away from Medicaid patients and towards MA** and commercially insured patients.

Importantly, **these changes continued after PE exited** from HCA in 2011 and HCA returned to public markets.

Private Health Plans Pay Significantly Higher Hospital Prices Than Medicare, Varying Widely by State and Hospital.

A recent *RAND Corporation study* highlights the significant price disparities that private health plans (with a focus on employer-sponsored health plans) pay for hospital services relative to Medicare across the United States. Key findings reveal that in 2022, commercial hospital prices averaged below 200% of Medicare prices in states like Arkansas, Iowa, and Massachusetts, while they exceeded 300% in states such as California, Florida, and New York. On average, **employers and private insurers paid 254% of what Medicare would have paid** for the same services at the same facilities. Employers need transparent and actionable price data to negotiate lower healthcare costs and ensure value for their employees.

Related Work:

- Addressing Site-of-Care Payment Differentials in the U.S. Health Care System | CAHPR Policy Brief
- How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan | Milbank Memorial Fund

MEDICARE ADVANTAGE

Health Risk Assessments in Medicare Advantage Drive Up Payments by $12 Billion Annually.

A study published in *Health Affairs* found that Health Risk Assessments (HRAs) significantly impact Medicare Advantage (MA) plan payments, contributing up to $12 billion annually. The study revealed that **44.4% of MA enrollees had at least one HRA**, leading to a 12.8% average increase in Hierarchical Condition Categories (HCC) risk scores, with substantial payment differences across contracts. Higher HRA-related HCC scores were associated with lower-quality plans, higher profit margins, and less provider integration. To mitigate excessive coding, **policy options limiting the risk-score impact of HRAs could reduce Medicare spending by $4.5–$12.3 billion annually.**

Financial Hardships Persist in Medicare Advantage Plans Despite Additional Benefits.

A study published in *Annals of Internal Medicine* compared the financial implications of MA and TM, finding minimal differences in out-of-pocket costs, **with a $168 annual increase associated with switching to MA**.

Moreover, vulnerable populations, especially those with low incomes, experienced heightened financial burden upon switching to MA. For instance, MA enrollees with mental health symptoms faced **higher out-of-pocket costs, with an average increase of $292 annually,** and had a 5% higher likelihood of having ongoing medical bill payments.

Furthermore, an analysis in *Health Affairs Scholar* of MA enrollment and post-acute nursing home care among patients with dementia **found no significant improvement in outcomes, despite a 50% relative increase in MA enrollment.** These studies suggest that MA's cost-saving strategies might not effectively reduce financial stress for high-need populations.

Legacy Medicare Advantage Plans Enrolled 1 in 6 MA Beneficiaries in 2020.

A study published in *JAMA Network Open* analyzing MA plans from 2011-2020 found that legacy-integrated MA plans like Kaiser Permanente and Geisinger, had beneficiaries who were **more likely to be older and non dually eligible, and less likely to be White** as compared to nonintegrated and non–legacy-integrated MA plans. As per plan characteristics, **legacy integrated MA plans had higher premiums ($54.89), superior star ratings (4.6), and lower HCC risk scores (1.0)** compared to non-integrated ($30.67; 3.5; 1.2) and non-legacy-integrated plans ($45.8; 3.6; 1.2).

Medicare Advantage Plans that adopt Supplemental Benefits have a Modest Increase in Plan Ratings.

Recent findings published in *JAMA Network Open* underscore the impact of expanded supplemental benefits on MA plan ratings. A cohort study on 388,000 MA enrollees across 467 contracts and 2,558 plans in 2021 found that **plans that adopted both Primarily Health-Related Benefits (PHRBs) and Special Supplemental Benefits for the Chronically Ill (SSBCIs) experienced a notable increase of 0.22 points (out of 10) in mean enrollee plan ratings**, compared to plans offering neither. Thus, adding supplemental benefits to MA plans may help address member needs while also potentially enhancing their CMS Star Ratings.

TRADITIONAL MEDICARE

BPCI-A Yields $421 Million in Incentives for Physician Groups, with Larger Bonuses Received during COVID-19.

A *Health Affairs* study examined the performance of physician group practices in the Bundled Payments for Care Improvement Advanced Model (BPCI-A) from 2018 to 2020. The study found that from 2018 to 2020, **physician groups earned $421 million in incentives,** with bonuses ranging from $139 to $2,775 per episode. **Higher target prices led to larger bonuses, emphasizing the need for accurate target setting**. While participation decreased over time, remaining practices, particularly during the COVID-19 pandemic received larger bonuses due to reduced post-acute care use as compared to the pre-pandemic cohort. These findings suggest that refining target prices and participation rules is essential as CMS expands BPCI-A and develops other payment models.

ETC Model Shows No Significant Impact on Home Dialysis and Kidney Transplants.

The End-Stage Renal Disease Treatment Choices (ETC) model introduced by CMS in 2021 aims to increase the use of home dialysis and kidney transplants. A recent study published in *JAMA Health Forum* analyzed 724,406 Medicare patients with kidney failure and **found no significant differences in the use of home dialysis or kidney transplants between ETC and non-ETC areas**. There were also no significant changes based on race, ethnicity, or income, or on outcomes like mortality and hospital admissions. These findings suggest that the ETC model, which is expected to run through 2027, has had limited impact and suggests that CMS should provide more resources, especially to high-risk facilities to improve use and monitor the impact to prevent further disparities.

Related Work: Evaluating the Impact and Consequences of ESRD Treatment Choices (ETC) Model | CAHPR Policy Brief

Bundled Payments Lead to Quality Improvements in Hospitals' Skilled Nursing Facility Referral Network.

A study in the *American Journal of Managed Care* looked at the impact of Medicare's BPCI program on hospital referral patterns and skilled nursing facility (SNF) quality for joint replacement patients. Hospitals participating in BPCI were **found to significantly reduce SNF discharges by 1.69 patients or 10% per year**. Moreover, hospitals did not change the number of SNF partners and overall referral concentration, thus preserving patient choice. Patients discharged to SNFs after BPCI participation were associated with small yet measurable patient outcome ratings, suggesting that BPCI can promote higher-quality post-acute care under cost-containment settings.

CAHPR IN THE MEDIA

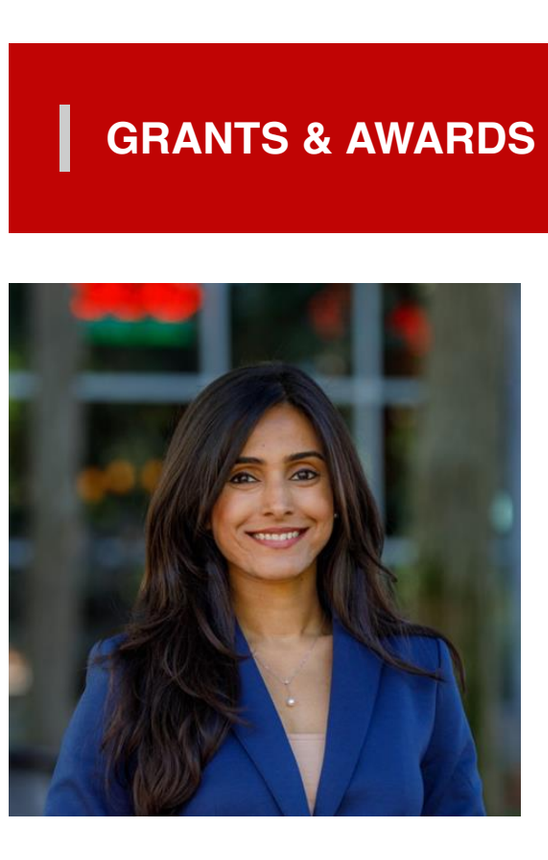
State Policies to Enhance Competition and Affordability

- Indiana hospital prices 8th-highest in the nation, study finds, but hospitals dismiss analysis | Indiana Capital Chronicle
- Take Five Interview with Chris Whaley, PhD | New Jersey Health Care Quality Institute
- State Treasurer Folwell Releases Report Finding North Carolina 340B Hospitals Overcharged State Employees for Cancer Drugs, Reaped Thousands of Dollars in Profits Per Claim | North Carolina Department of State Treasurer

Health Care Markets

- 'It isn't normal to operate the way they do': Senators condemn healthcare's resistance to price transparency | Fierce Healthcare
- RAND 5.0 Hospital Price Transparency Study: Key Results and Insights | The Alliance
- This $2.2 Billion Startup's GPT-4 Powered AI Bot Demystifies Health Insurance | Forbes
- Is Private Equity Ruining Health Care? It's Complicated | Tradeoffs Podcast
- Private equity escapes FTC in court, but anesthesia group doesn't |STAT News
- 'Very, very unusual.' Is Valley Children's taking more than it's giving back? | Fresnoland

GRANTS & AWARDS



Yashaswini Singh, PhD, MPA received the Outstanding Dissertation Award from AcademyHealth for her work on private equity and physician practice strategy in the United States.

TESTIMONIES AND BRIEFINGS

Health Care Price Transparency: Opportunities to Lower Costs and Improve Competition

by Christopher Whaley, PhD, July 2024, before the United States Senate Special Committee on Aging.

Read the press release

Watch the Testimony Highlights

Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing Economic Resiliency.

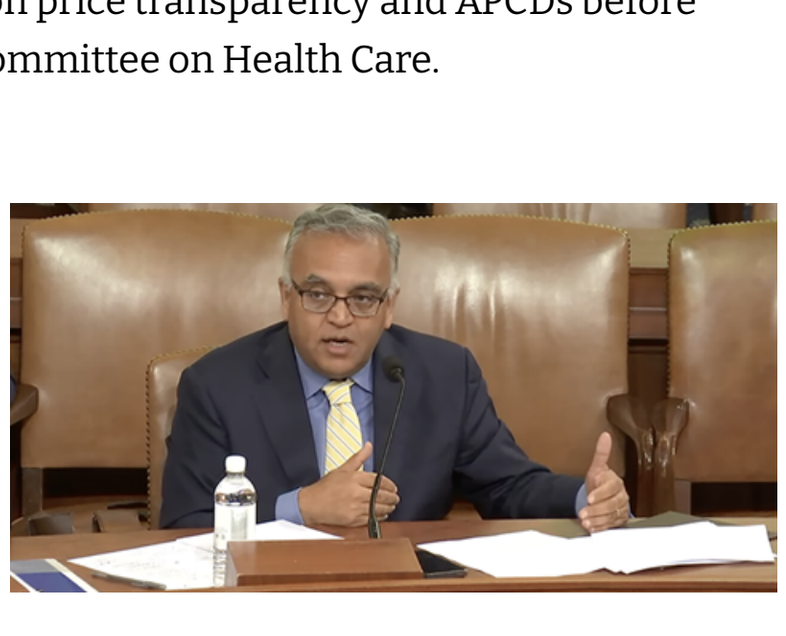
by Erin C. Fuse Brown, JD, MPH, June 2024, before the Senate Judiciary Committee

Price Transparency and Uses of All-Payer Claims Data

by Christopher Whaley, PhD, May 2024 on price transparency and APCDs before the Oregon State Legislature's Senate Committee on Health Care.

The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine

by Ashish K. Jha, MD, MPH, May 2024 to the House Committee on Ways and Means, Subcommittee on Health



Watch the Testimony Highlights

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, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.