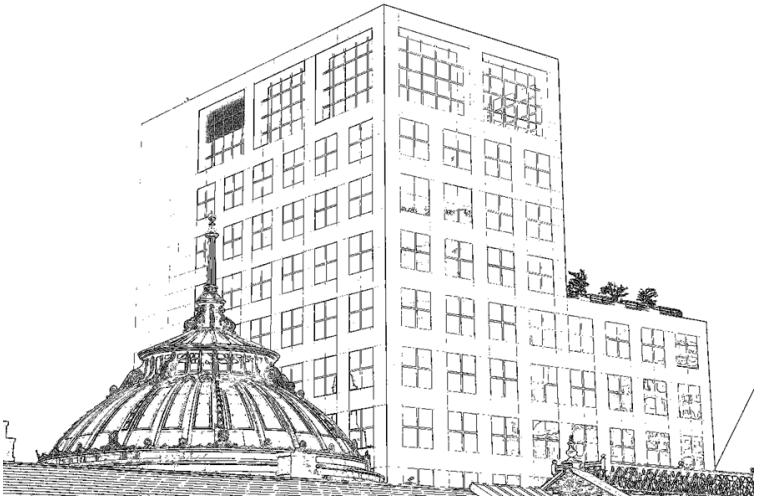
School of Public Health
BROWN UNIVERSITY

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH



RESEARCH HIGHLIGHT OF THE QUARTER

Hospital Payment Caps Could Save States $7.1 Billion While Preserving Hospital Margins

A *Health Affairs* study found that capping hospital payments for state employee health plans at 200% of Medicare rates would have saved states an average of $150.2 million each in 2022, totaling $7.1 billion nationally. Despite these savings, hospital commercial operating margins would remain healthy, dropping only slightly from 42.7% to 41.7%. Lessons from Oregon's payment cap demonstrate the potential for significant cost reductions without jeopardizing hospital networks or services. Policymakers are encouraged to explore these caps as a sustainable strategy to

reduce healthcare spending while maintaining access and care quality.

Building on this analysis, the Center for Advancing Health Policy through Research created the Hospital Payment Cap Simulator. This interactive tool provides policymakers, researchers, and other stakeholders with a clear visualization of potential savings from implementing hospital payment caps for state employee health plans. It also highlights the impact these caps could have on commercial hospital operating margins, offering valuable insights to support state reform.

MEDICARE

Combining Patient Surveys with Diagnosis Codes Enhances Medicare Advantage Risk Adjustment

In a study published in *Health Affairs*, CAHPR researchers found that integrating self-reported survey data with diagnosis codes significantly improves the accuracy of risk adjustment in MA. Traditional risk models explained 5.1% of the variation in MA utilization, while models combining surveys with diagnosis codes explained up to 6.0%. Survey-enhanced risk adjustment can limit the potential for upcoding while improving the predictive accuracy of risk adjustment. The findings highlight the value of including patient-reported health data to refine payment systems and improve care for high-need enrollees

Physician Diversity Gaps in Medicare Advantage Raise Equity Concerns

A *Health Affairs* study analyzing MA networks revealed that only 43.2% of Black physicians and 44.0% of Hispanic physicians were included in MA networks, compared to 51.1% of White physicians. Furthermore, 20% of Black and

Hispanic beneficiaries had no access to racially concordant physicians in their counties. This lack of diversity raises concerns, as research links physician-patient racial concordance with better care outcomes.

Dual-Eligible Patients Stuck in Lower-Rated Plans After Termination of D-SNP Look-Alikes

In 2023, CMS terminated "look-alike" Dual-Special Needs Plans (D-SNPs)—Medicare Advantage plans that resemble fully integrated D-SNPs but lack comprehensive coordination of Medicare and Medicaid benefits. A CAHPR study published in the *Journal of the American Geriatrics Society* found that this transition affected 200,476 beneficiaries, predominantly in California. Intended to transition dual-eligible enrollees into fully integrated care plans, only 6.3% moved to highly integrated options, while most shifted to lower-rated plans with reduced benefits. Moreover, Asian and Hispanic beneficiaries were disproportionately affected. As CMS expands this policy, stronger oversight is needed to ensure equitable transitions to high-quality, integrated care for dual-eligible populations.

Potential Excess Federal Spending on Dual Medicare Advantage and Veterans Health Administration Enrollees

The study published in *JAMA* finds that between 2011 and 2020, the number of dual enrollees in Medicare Advantage (MA) and Veterans Health Administration (VHA) increased by 63%, with the VHA spending on these individuals growing from $4.5 billion to $12.1 billion annually. Moreover, over the decade, the VHA spent a total of $78 billion on dual enrollees.

Medicare's TEAM Model: Challenges and Solutions

The Centers for Medicare and Medicaid Services will launch the Transforming Episode Accountability Model (TEAM) in January 2026, a mandatory bundled payment program to reduce healthcare costs. In this *New England Journal of Medicine* Perspective, CAHPR authors stress the need for better risk adjustment to protect hospitals serving marginalized populations, recommend shifting to hospital-specific pricing for fairness, and urge monitoring post-acute care impacts (given that bundled payments often reduce spending on post-acute care) to prevent burdening family caregivers - all to ensure the success of the TEAM program.

HEALTHCARE MARKETS

Healthcare Costs Rise as an Increasing Number of Primary Care Physicians Shift to Hospital and PE Ownership

The proportion of primary care physicians (PCPs) affiliated with hospitals rose from 25.2% in 2009 to 47.9% in 2022, with private equity (PE) -affiliated PCPs reaching 1.5%. In this study published in *JAMA Health Forum*, CAHPR authors analyzed over 226 million negotiated prices and found that hospital-affiliated PCPs charge 10.7% higher prices for office visits compared to independent practices, while PE-affiliated PCPs charge 7.8% more - raising concerns about higher costs for patients, and prompting calls for greater oversight and transparency in healthcare consolidation.

Over 5,000 Behavioral Health Facilities Acquired by Private Equity between 2010 and 2022

In a CAHPR study published in the *Journal of General Internal Medicine*, PE acquisitions in behavioral health have surged, growing from just 1 acquisition in 2010 to 176 acquisitions by 2022, spanning over 5,000 locations. Notably, more than

half of these acquisitions occurred after 2020, with hotspots in states like Virginia, Delaware, Colorado, and Georgia where PE-owned facilities account for over 40% of the market. As PE reshapes the behavioral health landscape, further research is required to study the long-term effects on care quality, access, and spending.

Unionization is increasing rapidly among physicians

In this *JAMA* study, CAHPR authors found that physician unionization efforts have accelerated dramatically, with 33 petitions filed from 2023 to mid-2024 alone—a 77% increase from the annual average from 2000 to 2022. Motivated primarily by working conditions, autonomy, and patient care concerns, these union drives reflect growing discontent in the industry with western states, like California, Oregon, and Washington leading in union activity. The majority of the petitions were filed against hospitals (49%) and community health centers (38%), while 13% of petitions targeted non-hospital corporate employers.

Strengthening Independent Physician Networks in the Face of Healthcare Corporatization

In this *New England Journal of Medicine* Perspective, CAHPR authors discuss how Independent Physician Associations (IPAs) and Clinically Integrated Networks (CINs) have emerged as alternatives, allowing physicians to share resources and negotiate contracts while avoiding full corporate integration. However, recent regulatory shifts by the FTC and DOJ have created uncertainty, limiting the ability of IPAs and CINs to negotiate contracts effectively. Strengthening these physician-led models is essential to counterbalance corporate dominance and ensure competitive, patient-centered care in a rapidly consolidating healthcare landscape.

HOSPITALS & HEALTH SYSTEMS

Two-Thirds of Hospital Coding Growth Linked to Upcoding: A $14.6 Billion Problem

In this study published in *Health Affairs*, CAHPR researchers analyzed 37.9 million discharges from 553 hospitals across Florida, Kentucky, New York, Washington, and Wisconsin, using State Inpatient Databases for 2011–2019. The study estimated that hospital upcoding contributed to two-thirds of the growth in high-intensity hospital discharges between 2011 and 2019, inflating healthcare costs by $14.6 billion in 2019 alone. Payments from private health plans, Medicare, and Medicaid totaled $5.8 billion, $4.6 billion, and $1.8 billion, respectively while Medicare saw the highest rate of upcoding growth. The most commonly upcoded diagnoses included heart failure and shock (+27% upcoding rate), chronic obstructive pulmonary disease (+17%), and simple pneumonia and pleurisy (+16%).

System Affiliation Helps Stabilize Struggling Rural Hospitals but Increases Costs for Patients

In a study published in *JAMA Health Forum*, CAHPR authors found that independent Critical Access Hospitals (CAHs) operate on slim margins, while system affiliation provides better negotiating power with insurers, leading to more robust financial performance. However, system affiliation, while improving financial stability for CAHs, also drives up costs for patients, with inpatient prices 7.1% higher for system-affiliated CAHs compared to independent ones. Policymakers must weigh the benefits of improved hospital sustainability through consolidation against the potential burden of increased patient costs, particularly in rural areas where access to care is critical.

Transparency Data Highlights Significant Disparities in Healthcare Pricing

New Transparency in Coverage (TiC) rules reveal significant price differences for common healthcare services across the U.S. A study published by CAHPR researchers in *JAMA Health Forum* analyzed Humana's data and found costs for an established patient office visit averaged $86, ranging from $69 to $93 across counties, while high-severity emergency department visits varied from $169 to $320. Geographic disparities were stark, with lower prices in the central U.S. and Florida, and higher rates in the upper Midwest and Southeast. These findings underscore the potential of TiC data to empower consumers, improve price transparency, and drive more equitable and efficient healthcare policies.

Healthcare Price Transparency Uncovers Opportunities to Reduce Costs

In this article published in the *Journal of General Internal Medicine*, CAHPR researchers identify striking price disparities for identical services, with physician-owned hospitals charging 18% less for outpatient procedures and ambulatory surgical centers offering colonoscopies at 36% lower costs than hospitals in the same areas. These findings highlight inefficiencies in the current system and support policies like site-neutral payments to standardize costs across care settings. Additionally, leveraging lower cash prices as benchmarks could help employers and policymakers negotiate fairer rates and promote competition. By leveraging newly available data on negotiated prices, stakeholders can drive affordability, reduce financial burdens, and foster a more competitive and transparent healthcare market.

CAHPR COMMENTARIES AND MEDIA MENTIONS

Private Equity and Health System Consolidation

> [California's Failed Bid To Regulate Private Equity Investment In Health Care] - Health Affairs Forefront
>
> [Indie No More: Nearly Half of Primary Care Docs Now Affiliated With Health Systems] - Medscape
>
> [Hospital, PE-affiliated PCPs demand higher prices, study finds] - Fierce Healthcare
>
> [The Gilded Age of Medicine Is Here] - The New Yorker
>
> [New Harvard study raises concerns about hospital control by private equity] - WBUR News
>
> [More primary care physicians are affiliated with hospitals, leading to increased patient costs] - Brown University
>
> [Doctors unions, like the one on strike at Providence, are growing more common] - Oregonian/OregonLive
>
> [UnitedHealthcare pays its Optum providers above-market rates] - STAT News

OHSU-Legacy Merger and Market Regulation

> [Oregon regulators plan deep dive on OHSU-Legacy merger- 6 things to know] - STAT News
>
> [Oregon health care regulator will review OHSU-Legacy merger] - Portland Business Journal
>
> [OHSU's takeover of Legacy Health would violate federal market standards, advocates say] - The Lund Report

Critical Access Hospitals

> [Critical Access Hospitals Feel Unique Financial Strain] - **HealthLeaders**
>
> [Critical access hospitals face uphill battle: 6 things to know] - **Becker's Healthcare**

Medicare and Medicare Advantage

> [Medicare Advantage insurers fear losing millions over a few bad phone calls - The Washington Post] - **The Washington Post**
>
> [Private Medicare plans get billions for veterans who get VA care] - **STAT News**
>
> [The Sickest Patients Are Fleeing Private Medicare Plans—Costing Taxpayers Billions] - **The Wall Street Journal**

Hospital Payment Caps and Cost Control

> [Hospitals cry foul as public option enrollment rises] - **Modern Healthcare**
>
> [How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan] - **Milbank Memorial Fund**
>
> [Study: Hospital payment caps could save millions for state employee health plans] - **Providence Business News**
>
> [Hospital payment caps could save millions of dollars for state employee health plans] - **Medical Xpress**
>
> [Hospital payment cap slashes prices in Ore.] - **TechTarget**
>
> [Hospital Payment Caps: 'Band Aid' or Promising Cost-Control Solution?] - **AIS Health**

> [Researchers: Hospital Payment Caps Could Safely Save Millions] - Healthcare Innovation

General Policy Insights

> [Can Public Option Plans Improve Affordability? Insights From Colorado] - Health Affairs Forefront
>
> [Congress can end the year on a rare bipartisan health care high note] - STAT News
>
> [How Research Shapes Health Policy on Capitol Hill] - Humans in Public Health Podcast
>
> [Health system ownership with Hayden Rooke-Ley] - Turn on the Lights Podcast

GRANTS & AWARDS

The Physician Practice Ecosystem over the Private Equity Life Cycle

Dr. Yashaswini Singh, PhD, MPA is awarded a grant by the Commonwealth Fund to investigate the impact of PE investment and exit strategies on physician practices, patient outcomes, and the healthcare workforce. By analyzing PE investments from 2015–2022, the study aims to provide policy-relevant insights into whether PE's effects are temporary or enduring, offering critical guidance for regulators.

Understanding Price Variation Using Transparency in Coverage (TiC) Data

In many U.S. healthcare markets, commercial insurance prices vary greatly; however, the full extent of price variation has been understudied to date largely due to limited data. **Dr. Christopher Whaley, PhD** has been awarded a grant from the National Institute for Health Care Management (NIHCM) to use recent, mandated TiC data to describe healthcare price variation across procedures, providers, insurers, and markets and identify the characteristics associated with healthcare price variation.

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.