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INITIATIVE FOR HEALTH POLICY

Economic Studies
The Brookings Institution
1775 Massachusetts Ave NW
Washington, DC 20036

Responses to Questions for the Record
Loren Adler, MS
Associate Director and Fellow, USC-Brookings Schaeffer Initiative for Health Policy
Economic Studies, Brookings Institution

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Committee on Energy and Commerce
Subcommittee on Health

Lowering Unaffordable Costs:
Legislative Solutions to Increase Transparency and Competition in Health Care

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Honorable Gus Bilirakis

1. **When we talk about competition, we have to think about it holistically. We can't just talk about hospitals, we have to talk about payers as well. I am a strong supporter of the Medicare Advantage program and believe in it as a long-term part of making Medicare solvent. But we know the landscape is rapidly changing as the health care system vertically consolidates beneath payers. And policymakers need to understand what that means for seniors and taxpayers What incentives are created when the same entity owns the insurance company responsible for paying for care, the doctor responsible for providing care, the pharmacy that dispenses medication, and the PBM that decides how much patients pay for that medication?**

There has indeed been a growing trend toward insurer ownership of physician practices, pharmacy benefit managers (PBMs), and pharmacies. These arrangements create multiple incentives.

On the one hand, insurer integration with physicians or pharmacies may enhance incentives to reduce costs. For instance, a primary care physician aligned with an insurer may be more likely to refer a patient needing specialist or hospital care to lower-priced alternatives because the same entity is now responsible for those specialist or hospital costs. These arrangements also increase the incentive to reduce premiums because added enrollees now create provider-level, insurer-level, PBM-level, and pharmacy-level profit margins for the payer.

On the other hand, some payer acquisitions will directly increase horizontal consolidation in physician, ambulatory surgery center (ASC), PBM, or pharmacy markets, which may lead to higher prices. This vertical integration may also generate incentives to raise the price of the insurer-owned physician services to competing insurers (or refuse to contract with them altogether). For example, an acquired physician group might terminate contracts with competing insurers or demand higher prices to remain contracted, thereby making competing insurance plans less attractive to consumers and increasing enrollment in the vertically integrated insurer's plans. Financial integration between payers and physicians will also tend to enhance incentives for the aligned physicians to code patients more intensely in order to generate higher payments to the payer's Medicare Advantage products and larger Affordable Care Act risk adjustment transfers from other plans.

2. **What behavior does this vertical consolidation drive?**

In the previous answer, I discuss the incentives that are likely created. We have limited evidence to date, however, about the effects of this vertical consolidation on behavior. One area where we do have strong evidence is that Medicare Advantage plans with vertically-integrated providers generated patient risk

scores 16% higher than would have resulted in traditional Medicare, whereas non-integrated plans generated risk scores that were 6% higher.[1]

3. **Is it driving competition in the health system or does it cause anticompetitive behavior?**

To the extent insurer acquisitions of physician practices, PBMs, and pharmacies are horizontally consolidating those markets, it will likely drive anticompetitive behavior. The vertical relationships may also lead to anticompetitive behavior in the form of efforts to raise competing insurers' costs.

On the other hand, payer ownership of primary care practices and ASCs may enhance competition in hospital and outpatient service markets.

4. **In many cases there are efficiencies to be gained from integrating care. But these arrangements, which in many cases are novel and growing rapidly, demand transparency into how they are affecting patient care and health costs. Do you support the discussion draft that would gather information on these vertically-integrated arrangements in Medicare Parts C and D, and if so can you speak to why?**

5. **Do you have any recommendations for the Committee as we attempt to get more information on the topic of vertically-integrated arrangements and consolidation among providers?**

Taking questions 4 and 5 together, I agree that more transparency into these vertical arrangements could be immensely valuable. At present, it is difficult to identify which physician groups are owned by payers and there are gaps in the Medicare Advantage data that is made available to researchers.

Along with Matthew Fiedler and Benedic Ippolito, we wrote extensively on these questions in a piece titled "Assessing recent health care proposals from the House Committee on Energy and Commerce", excerpted below:

> *Perhaps the most potentially impactful transparency bill put forward by the subcommittee would generate publicly-available data on the parent company and ownership structure of health care providers. Specifically, the proposal would require certain providers—physician groups, hospitals, ASCs, and freestanding emergency departments—to report this information to the Department of Health and Human Services (HHS), along with any mergers, acquisitions, or changes in ownership over the prior year. HHS would then be required to make these data publicly available.*

[1] Geruso, Michael, and Timothy Layton. "Upcoding: Evidence from Medicare on Squishy Risk Adjustment." *The Journal of Political Economy*, U.S. National Library of Medicine, Mar. 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7384673/

Data like these would facilitate several types of important analyses. For example, by making available information on each entity's ultimate parent company, it would allow agencies and researchers to more easily and accurately track horizontal consolidation in physician and facility markets and trace its effects. Information on ownership structure would also provide an up-to-date snapshot of emerging trends in different forms of corporate ownership of health care providers, as well as allow for stronger analysis of the effects of private equity, hospital, and payer acquisitions of physician practices.

Some similar data are already being reported to the Centers for Medicare and Medicaid Services (CMS), but the bill would greatly improve what is readily available to researchers, especially with respect to physician groups. In particular, there currently is no comprehensive source of data that makes it possible to identify which physician groups share a common owner or determine the ownership structure of the entity with a controlling ownership interest in the group (e.g., private equity, insurer, or hospital).

In detail, physician groups are identified in Medicare claims data by their tax identification number (TIN). But in many cases, large parent companies own and operate many TINs. For instance, Envision, owned by private equity firm Kohlberg Kravis Roberts (KKR), operates more than 100 TINs in its emergency medicine staffing business. Moreover, matching TINs to their parent company and the ownership structure of that parent company is often complex and difficult to automate. The best starting point at present is the Medicare Data on Provider Practice and Specialty (MD-PPAS) data extract, which researchers can purchase from CMS. These data include the legal name associated with physician group TINs, from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data, and some information on the geographic location where a clinician delivers most of his or her Medicare services.

But that information is often inadequate to identify a practice's parent company. Researchers are therefore forced to identify parent companies by piecing together additional information on ownership from various sources, which make this type of research very resource-intensive and thus limits how much can be done. This manual work also inevitably ends up incomplete, which can result in researchers underestimating the level of market concentration, among other potential problems. Ideally, this proposed legislation would lead to CMS releasing a more robust version of the MD-PPAS data extract that additionally includes the parent company and ownership structure of each physician group TIN (or otherwise link TINs to the relevant parent company and its ownership structure).

Another bill considered by the subcommittee also aims to increase the transparency of health care ownership arrangements, with a focus on vertical integration between health plans and providers and in-home medical assessment entities. The bill requires Medicare Advantage Organizations (MAOs) to disclose certain data, including about average enrollee utilization, diagnoses, risk scores, and spending, broken out by whether enrollees' had received services from a provider integrated with the MAO. (The bill would also require certain reporting by prescription drug plan sponsors, pharmacy benefit managers, and pharmacies, which we discuss in a later section.)

As discussed above, we believe that greater disclosure of information about ownership arrangements has high value. If those data can be linked with health care claims data,

researchers can then answer a wide range of questions about the behavior of, in this case, vertically integrated entities. In the case that no such linkage is feasible, collecting certain aggregated data—as envisioned in this bill—can also be useful if the data offer insight into business practices and are not otherwise attainable. However, many of the comparisons that could be made using aggregate data requested in this bill would be quite vulnerable to confounding from unobserved differences in patient characteristics, which makes us question whether it is worth bearing the (modest) administrative burdens required to collect them.

As an alternative, we suggest pursuing the enhanced reporting on provider ownership discussed earlier in this section in tandem with improvements to the Medicare Advantage (MA) encounter data available to researchers. Most importantly, CMS should release payment and cost-sharing information it collects with the encounter data, which it currently withholds. It should also begin collecting information on plans' non-fee-for-service payments to providers (e.g., shared savings or shared loss payment), which are not captured in traditional claims data. To facilitate analysis of how vertical integration affects the intensity of diagnosis coding, CMS could also give researchers access to enrollee-level risk scores for years other than 2014.

6. **As we know, the trust fund that supports Medicare hospital coverage runs out in 6 years. Research shows physician-led hospitals produce savings for Medicare and are more cost-effective than other hospitals. Physician-led hospitals participated in one of the DRGs for the Center for Medicare & Medicaid Innovation's joint replacement demonstration. 72% of participating physician-led hospitals produced savings – much more than the 52% of other hospitals achieving this goal. If we are serious about addressing Medicare solvency, can you think of a reason why we shouldn't look at physician-owned hospitals to help bring down costs**

I do not know of strong evidence that speaks to effects of allowing physician-owned hospitals, but the case for disallowing them appears weak. Even if the effects of allowing physician-owned hospitals would be small, the bar should be high to limit competition in health care markets.