

Medicare Advantage and Vertical Consolidation in Health Care

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EXECUTIVE SUMMARY

A new wave of health care consolidation is underway. Health insurance and retail conglomerates are rapidly acquiring providers, from primary care practices and surgery centers to home-based and post-acute care. UnitedHealth Group (UnitedHealth), for example, is now the nation's largest insurer and the largest employer of physicians. Humana is now the largest provider of “senior-based” primary care and in-home care. CVS Health, Walgreens, and Amazon, which have been aggressively consolidating the prescription drug supply chain, are now acquiring physician practices. And private equity investors—looking to consolidate industry segments and then sell to these conglomerates as an eventual exit—are accelerating these rollups.

With dominant market power, the new health care conglomerates can dictate which physicians patients can see, which medications are prescribed to them, and which insurance plans they enroll in. By acquiring medical practices, these corporate employers can shorten visit times, require more clinical coding and box-checking, and replace physicians with lower-cost clinicians. Meanwhile, by coordinating across lines of business, conglomerates like UnitedHealth can squeeze out independent practices and community pharmacies. They can also shuffle money between subsidiaries and use other financial tactics to skirt regulations and exploit payment loopholes, increasing health care costs.

This paper details the causes and costs of this new frontier of consolidation and offers a set of solutions to address it. In short, sweeping changes in health care financing policy are causing insurers and retailers to restructure as vertically integrated conglomerates. While technical, how the government pays providers and insurers fundamentally shapes the business strategies of health care companies. As the government continues to privatize Medicare and Medicaid, it is significantly overpaying insurance companies to administer benefits. With this excess capital, these insurers are acquiring providers, gaining control of key points in the delivery system that enable them to capture greater government payments and minimize spending on patient care. To take one prominent example, control over primary care clinicians allows these corporate owners to manipulate billing and coding practices to make patients appear sicker to the government, thereby increasing payments.

Part I of this paper explains how government policy over the last two decades has transformed health care financing. In an attempt to solve health care's value problem—high spending and poor health outcomes—policymakers have steadily abandoned “fee-for-service” financing, in which medical providers are reimbursed for each service that a patient receives. Instead, public programs have increasingly adopted “capitation-based” financing. In this model, the government pays a fixed budget to a “risk-bearing entity”—an insurance company, hospital system, or group of physicians—to manage the total health care costs for a patient. The risk-bearing entity turns a profit if it keeps costs below the

established budget, which is adjusted based on the perceived sickness of the population and metrics of care quality. In this paper, this policy agenda and its underlying ideological framework are referred to as health policy’s “Capitation Consensus.”

Medicare Advantage, the privatized version of Medicare that now covers more than half of Medicare beneficiaries, is the most prominent example of the Capitation Consensus. But this financing approach has spread across public health care programs: nearly all of Medicaid has moved to capitation-based financing, and Medicare’s prescription drug benefit, Part D, operates entirely on capitation. In the last decade, traditional Medicare—the historically fee-for-service model of Medicare—has been integrating versions of capitation through accountable care organizations and other value-based care models. Despite high hopes, the shift to capitation has yet to deliver on its primary objective of cost reduction. Most concerning is that Medicare Advantage now costs taxpayers anywhere from \$75 billion to \$140 billion annually in over-subsidization relative to traditional Medicare.

Part II of this paper explains how the Capitation Consensus is driving vertical consolidation. With excess capitation payments, Medicare Advantage insurance conglomerates are plunging capital into provider acquisitions, and retailers and private equity investors are following suit. As noted above, owning physician practices enables conglomerates to inflate the perceived disease burden of patients, thereby enhancing capitation-based payments from the government. Vertical consolidation also enables patient steering: conglomerates can push patients to receive care at their own provider subsidiaries. In doing so, these companies squeeze out local providers, such as independent physician practices and community pharmacies. Steering also generates “captive revenue,” which allows conglomerates to game federal regulations requiring that government payments are spent on patients, not profits. Further, these conglomerates use their insurance-side subsidiaries to pressure independent practices to sell to their provider-side subsidiaries, effectively “flipping” new patients to their own medical practices and insurance plans.

Turning to solutions, Part III of this paper argues for an alternative policy framework—aimed at a new “industrial policy” for health care—that would depart from the Capitation Consensus and center at least three principles. First, this approach would be suspicious of concentrated corporate power—whether horizontally or vertically combined—and would promote the autonomy and collective power of clinicians. Second, it would revive a legal and policy focus on the ownership structure and governance of health care providers, protecting the medical profession from corporate influence and minimizing financial strategies that increase prices and administrative costs. Third, a proactive health care industrial policy would emphasize the “supply side”: how policymakers, particularly in Medicare, can exercise greater control of public money and directly rationalize the production and allocation of health care capacity.

The paper offers two sets of policy recommendations. The first would directly combat the emerging forms of vertical consolidation that are fueled by the Capitation Consensus. The second set of policies offers alternatives to large-scale, investor-driven health care. These proposals are geared toward building robust health care infrastructure—owned by clinical providers and local communities—that meets growing care needs and is insulated from corporate consolidation.

SUMMARY OF POLICY RECOMMENDATIONS

COMBATING VERTICAL CONSOLIDATION

- **Require Transparency in Ownership:** State and federal lawmakers could update transparency laws to illuminate the nature and extent of vertical consolidation and corporate ownership.
- **Reduce Medicare Advantage Overpayments:** Congress and the health agencies can pursue a range of options to stop over-subsidizing Medicare Advantage.
- **Update Medical Loss Ratio (MLR) Requirements:** Congress can raise the MLR requirement, now set at 85%, to align with other advanced countries. Policymakers can also require transparency in pricing to protect against MLR gaming.
- **Invest in Traditional Medicare:** Congress should use savings from Medicare Advantage reform to expand benefits and lower cost-sharing in Medicare. Medicare reform should also stop the emerging trend in which providers only accept Medicare Advantage, not traditional Medicare.
- **Enforce Antitrust Laws:** Congress and executive agencies can update and better enforce antitrust law, and states can pursue similar enforcement, as some already have.
- **A Glass-Steagall for Health Care:** Borrowing New Deal banking reform, Congress could bar insurance companies, or at least certain types, from owning providers.
- **Repurpose Bans on the Corporate Practice of Medicine:** States, with the support of the federal government, can update and repurpose dormant bans on the corporate practice of medicine (CPOM) to address various forms of corporate ownership and investment.
- **Regulate Facility Ownership:** Policymakers can better regulate ownership and governance of institutional providers, such as hospitals, nursing facilities, and home health providers.

- **Support Countervailing Power:** States and the federal government can ban certain contracting practices used to control clinicians, such as noncompete agreements. Lawmakers should also support health care union activity, including the surge in physician unionization.

BUILDING RESILIENT HEALTH CARE INFRASTRUCTURE

- **Produce and Allocate Physicians:** Medicare, as the largest payer for health care services and the direct funder of graduate medical education, should be far more active in increasing and rationally allocating physician supply.
- **Invest in Primary Care and Fix the Relative Value System (RVS) Update Committee:** Policymakers can drastically increase primary care investment and properly calibrate reimbursement disparities across specialties. This requires that Medicare claim the primary role of setting physician pay, rather than deferring to a specialist-dominated physician lobby.
- **Simplify Financing in Primary Care:** Reimbursement should move toward lump-sum payments (without total-cost risk-bearing) that support primary care teams. These payments would be standardized across payers, or removed from insurance and publicly financed, as part of much-needed integration with our public health system.
- **Promote Physician and Public Ownership:** States and the federal government can promote physician-led ownership through the tax code. States also have numerous tools, with historical precedent, to publicly acquire struggling practices and hospitals, and to publicly build where capacity is needed.
- **Hospitals as Public Utilities:** Hospitals, similar to primary care, should be viewed as critical infrastructure and protected from harms of corporate consolidation. They should also be the focus of cost containment through the regulation of prices and administrative costs. Policies could include strengthened conditions of participation and nondiscrimination laws, rate regulation, and all-payer rate-setting. Ultimately, payment should move toward “operational” global budgets, which would strictly fund operations, cap profits and administrative waste, and untether capital financing from operations.

I. THE RISE OF THE CAPITATION CONSENSUS

American health care has a well-known value problem. As a share of GDP, the United States spends nearly twice as much (17.8%) as the average OECD country. Yet high health care spending doesn't translate into better health outcomes. Affordability and access are also lackluster. Caretakers are underpaid and overworked, and physicians are increasingly burnt out.¹

In recent decades, policymakers have pursued a distinctive approach to enhancing value. In the government's two largest public health programs, Medicare and Medicaid, there has been a sweeping effort to move away from traditional fee-for-service financing and toward forms of capitation-based financing—referred to here as health policy's "Capitation Consensus." As argued in this part, financing models under the Capitation Consensus attempt to incentivize the private sector to better manage the total use of health care services, even though excess health care spending is largely driven by high prices and administrative costs, not excessive utilization. This helps explain capitation's underwhelming record on cost reduction, its primary objective.

A THEORY OF UTILIZATION MANAGEMENT

The Capitation Consensus is a departure from traditional fee-for-service financing, in which the government reimburses providers on a per-service basis. Under capitation-based models, the government delegates the management of total health expenditures to private "risk-bearing entities." In a traditional capitation arrangement, like Medicare Advantage (MA) or Medicaid managed care, this risk-bearing entity is a private insurance company that receives a flat per-member, per-month payment from the government. In accountable care organizations (ACOs) and other value-based care arrangements, the risk-bearing entity is a hospital or a group of physicians that similarly receive a total-cost budget to manage. If the patient's medical costs are lower than the capitated budget, the risk-bearing entity profits.

The theory behind the Capitation Consensus is that private-sector management of health care utilization will reduce aggregate health care spending. Under capitated budgets, insurance companies will manage the use of services through a host of familiar strategies—prior authorization, narrow networks, and forms of benefit design

¹ Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes," The Commonwealth Fund, January 31, 2023; Nada Hassanein, "A third of Americans don't have a primary care provider, report finds," *USA Today*, February 28, 2023.

that incentivize the patient to use certain types of services over others. In value-based care models, physicians and hospitals become the locus of utilization management. In theory, whereas providers under fee-for-service are incentivized to render excess care, capitation-based models incentivize providers to avoid unnecessary care, reduce referrals to expensive specialty and hospital care, and manage chronic conditions that lead to downstream costs.² Under these models, consolidation between hospitals, physicians, and insurers is not presumptively a problem—in fact it is potentially efficiency-enhancing.³ Instead of contracting at arm’s length, firms will reduce the transaction costs, coordinate data and workflows, and ultimately lower costs.⁴

This theory of cost-containment rests on an empirical assumption: that Americans overuse health care services, and, therefore, controlling utilization is the obvious way to manage costs. But since the early 2000s, when capitation-based financing began to accelerate in government programs, evidence has shown that Americans do not, by and large, overuse health care services. Indeed, as explained in a landmark 2003 article by Gerard Anderson and colleagues, “It’s the Prices, Stupid,” health service use in the United States was below the median for OECD peer countries. High aggregate costs were attributed to high unit prices.⁵ This finding has been borne out repeatedly in the subsequent decades, including in 2019, when the authors of the 2003 study re-ran their analysis with updated data and concluded that “prices are the primary reason why the US spends more on health care than any other country.”⁶ Demonstrating America’s persistent price problem, the bulk of cost growth in the United States since 2004 is attributable to increased prices.⁷

A major driver of high prices is America’s unparalleled administration costs, including embedded profits, which far exceed our peer nations.⁸ These high costs are driven by the complexity of our system, with countless insurers and intermediaries, and profits accrued at every level. By a conservative estimate, the United States spends \$1,055 per capita on administrative costs, while the next highest, Germany, spends \$306 per capita.⁹ On the high end of estimates, a 2020 study found that administrative costs were \$2,497 per capita, or \$812 billion, and 34.2% of national health expenditures.¹⁰

2 Elliott S. Fisher, “Medical Care—Is More Always Better?,” *New England Journal of Medicine*, October 23, 2003, (“[C]urrent incentives must change, since they contribute to the overuse of discretionary services.”).

3 Steven C. Salop, “Invigorating Vertical Merger Enforcement,” *Yale Law Journal*, May 2018.

4 Erin Fuse Brown and Jaime King, “The Double-Edged Sword of Health Care Integration: Consolidation and Cost,” p. 62, *Indiana Law Journal*, 2016.

5 Gerard F. Anderson et al., “It’s The Prices, Stupid: Why The United States Is So Different From Other Countries,” *Health Affairs*, June 2003.

6 Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, “It’s Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt,” *Health Affairs*, January 2019; Luca Lorenzoni, Annalisa Belloni, and Franco Sassi, “Health-care expenditure and health policy in the USA versus other high-spending OECD countries,” *The Lancet*, June 30, 2014; Irene Papanicolas, Liana R. Woskie, Ashish K. Jha, “Health Care Spending in the United States and Other High-Income Countries,” *JAMA*, March 13, 2018.

7 David Dranove and Lawton Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, p. 82, University of Chicago Press, 2021.

8 “How Does the US Healthcare System Compare to Other Countries?,” The Peter G. Peterson Institute, July 12, 2023.

9 Id.

10 David U. Himmelstein, Terry Campbell, and Steffie Woolhandler, “Health Care Administrative Costs in the United States and Canada, 2017,” *Annals of Internal Medicine*, January 7, 2020.

These costs are incurred by both payers and providers, which devote substantial resources to their contracting interactions, to billing and coding for each encounter, and compliance with (and often gaming of) quality payments and reporting.¹¹ Fully insured private payers spent 15.3% of premiums on administrative costs in 2010-2012.¹² MA plans spent 13.6% on administrative costs in 2011.¹³ Meanwhile, the overhead for traditional Medicare in 2012 was 1.8%, similar to Canada.¹⁴ Hospitals spend over 26% of their revenue on administration, which is twice as much as in Canada, and hospitals retain another 6%-7% of revenue as profits, or “surplus” for nonprofit hospitals.¹⁵ In 2011, for every physician, practices spent \$83,000 on administrative costs, a number that is doubtless higher today with the increased compliance burdens of quality reporting and other value-based payments.¹⁶ Furthermore, like high prices, high administrative costs are nothing new: a 2004 study found that administrative costs in the United States were 26% of total expenditures.¹⁷

Nonetheless, overutilization concerns have been a feature of policy discourse since the 1980s. Beginning with concerns about the “moral hazard” of insurance, economists such as Kenneth Arrow and Mark Pauly promoted high-deductible insurance to incentivize patients to constrain their use of care.¹⁸ By the early 2000s, reformers would also look to the incentives of physicians to control utilization. Research from the highly influential Dartmouth Atlas Project showed that regions with high Medicare spending did not correlate with quality.¹⁹ The researchers, in publicly discussing their findings, would extrapolate and argue that all health care spending could drop by as much as 30% if providers across America adopted the practice patterns of the lower-spending regions.²⁰ Popularized by Dr. Atul Gawande of the *New Yorker*, this research became the centerpiece of the Affordable Care Act’s commitment to capitation-based models as the vehicle for cost control.²¹ However, as the *New England Journal of Medicine* and the *New York Times* would later report, this research made significant assumptions about modifiable utilization,

11 Matthew Fiedler, “Testimony Before the United States Senate Committee on the Budget,” October 18, 2023; Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021-2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

12 “Private Health Insurance Premiums and Federal Policy,” Congressional Budget Office, February 2016.

13 “Medicare Advantage: 2011 Profits Similar to Projections for Most Plans, but Higher for Plans with Specific Eligibility Requirements,” United States Government Accountability Office, December 2013.

14 “2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2021.

15 Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021-2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

16 “Physician Practices in the U.S. Spend Nearly \$83,000 Annually Per Physician on Administrative Costs, Nearly Four Times as Much as Canadian Practices Spend,” The Commonwealth Fund, August 4, 2011.

17 David U. Himmelstein, Steffie Woolhandler, and Sidney M Wolfe, “Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings,” *International Journal of Social Determinants of Health and Health Services*, January 2004.

18 Allison Hoffman, “Health Care’s Market Bureaucracy,” *UCLA Law Review*, 2019.

19 Elliott S. Fisher, “Medical Care—Is More Always Better?,” *New England Journal of Medicine*, October 23, 2003.

20 Reed Abelson and Gardiner Harris, “Critics question study cited in health debate,” *The New York Times*, June 2, 2010.

21 Erin Fuse Brown and Jaime King, “The Double-Edged Sword of Health Care Integration: Consolidation and Cost,” p. 57, *Indiana Law Journal*, 2016.

especially at the end of life.²² Further, subsequent evidence has shown that variation in Medicare spending should not be extrapolated to the private commercial market.²³ It also didn't appear as if other evidence at the time substantiated the Dartmouth team's theory of waste. A 2012 meta-analysis of 114,831 papers published over the period 1978-2009 found only 172 studies documenting overuse, concluding that "robust evidence about overuse in the United States is limited to a few services."²⁴ Notably, more recent articles on the sources of waste in America do not appear to cite the Dartmouth Atlas.²⁵

To be sure, many Americans receive low-value or excessive care that contributes to downstream costs. But given that uniquely high expenditures in the United States have long been driven by out-of-control prices, it's not obvious that the optimal way to manage costs is to manage the utilization of services. As discussed in the proceeding parts, policy schemes of private rationing of services come with significant risks, which must be weighed against sober projections of cost reduction and alternative approaches to enhancing value.

A FAILURE ON COST REDUCTION

Despite the foregoing evidence of persistently high prices, capitation-based models have become the consensus approach to improving value in health care. This section traces the formation of the Capitation Consensus within Medicare and Medicaid and discusses its fiscal performance. Medicare Advantage (MA), the "purest" form of capitation, now costs the government significantly more than traditional Medicare. Forms of capitation-based models within traditional Medicare are not nearly as fiscally problematic, but even the most successful models have achieved minimal savings. The same is true for Medicaid privatization, which has largely broken even, fiscally.

I. MEDICARE ADVANTAGE AND MEDICARE PART D

MA is the most prominent example of the Capitation Consensus. Known as "full capitation," the MA program furnishes monthly per-enrollee payments to private insurance plans to create and administer the Medicare benefit. The capitated payments are based on county-level per capita traditional Medicare spending levels (called "base payments") and adjusted for the disease burden of the population (called "risk adjustment"), and for the

22 Reed Abelson and Gardiner Harris, "Critics question study cited in health debate," *The New York Times*, June 2, 2010; Peter Bach, "A Map to Bad Policy — Hospital Efficiency Measures in the Dartmouth Atlas," *New England Journal of Medicine*, February 18, 2010.

23 Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *NBER*, December 2015.

24 Deborah Korenstein et al., "Overuse of Health Care Services in the United States," *JAMA*, January 23, 2012.

25 William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System Estimated Costs and Potential for Savings," *Health Affairs*, August 9, 2020.

insurer's performance on a set of quality metrics (called "Star Ratings").²⁶ In contrast to traditional Medicare, MA insurers manage costs in ways familiar to private managed care: constricting the network of providers, requiring prior authorizations, denying services, and designing premiums and cost-sharing to encourage certain utilization patterns.²⁷

MA is an outgrowth of health maintenance organizations, or HMOs. Prior to Medicare's passage in 1965, certain large employers began to make global payments to provider systems, HMOs, to cover all the care of their employees. As these patients retired, Medicare created a capitation option to replicate HMOs.²⁸ With the introduction of private health insurance companies to administer Medicare plans in 1982, this model began to transform into what we know as MA today. No longer reflecting organic, physician-led integrated delivery, HMOs in MA (and the commercial market) are now mostly insurance products with restrictive networks.

Contrary to its theory and legislative intent, MA has always cost more per person than traditional Medicare. MA payments were initially 5%-7% higher per person, on a risk-adjusted basis, than traditional Medicare because insurance plans selectively recruited healthier patients with historically low expenditures.²⁹ In 1997, Medicare sought to correct for selection by introducing "risk adjustment." But that, too, would generate a new form of gaming: MA plans, as explained in detail in Part II, could increase capitated payment from Medicare by making their enrollees appear sick via documentation of clinical diagnoses. By 2009, MA payments were 14% higher than traditional Medicare for populations with comparable health risk.³⁰ In 2010, though Congress reduced base-level capitated payments, it created a new source of arbitrage through geographic and quality bonuses, also explained in greater detail in Part II.

Today, the sum of overpayments in MA (relative to expenditures if the patients were in traditional Medicare) are estimated to range from 20%, or \$75 billion, to 35%, or \$140 billion annually.³¹ As detailed later, MA plans can selectively enroll patients who incur lower spending than expected based on their risk-adjusted benchmark. For the high-end estimations, selection effects account for 11% to 14% of the overpayments, or nearly \$60

26 Erin C. Fuse Brown et al., "[Legislative and Regulatory Options for Improving Medicare Advantage](#)," *Journal of Health Politics, Policy and Law*, December 1, 2023.

27 Laura Skopec, Robert A. Berenson, and Judith Feder, "[Why Do Medicare Advantage Plans Have Narrow Networks?](#)" The Urban Institute, November 2018.

28 Id.

29 Erin C. Fuse Brown et al., "[Legislative and Regulatory Options for Improving Medicare Advantage](#)," *Journal of Health Politics, Policy and Law*, December 1, 2023.

30 January Angeles and Edwin Park, "['Upcoding' Problem Exacerbates Overpayments to Medicare Advantage Plans](#)," Center on Budget and Policy Priorities, September 14, 2009.

31 Stuart Hammond, Andy Johnson, and Luis Serna, "[The Medicare Advantage Program: Status Report](#)," MedPAC, January 12, 2024; Steven M. Lieberman, Paul Ginsburg, and Samuel Valdez, "[Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments](#)," USC Schaeffer, June 13, 2023; "[Our Payment Their Profits](#)," Physicians for a National Health Program, October 4, 2023.

billion in projected overpayments in 2023.³² Another 12% of overspending, at the least, results from risk adjustment arbitrage, and gaming of quality and geographic bonuses.³³ Some scholars contend that there is an additional source of overspending called “induced utilization.” This excess spending arguably arises because Medicare establishes MA capitation rates using the spending patterns of traditional Medicare patients, many of whom have purchased supplemental insurance and therefore have higher spending patterns.³⁴ Overall, such significant over-subsidization has caused Medicare to transform in strikingly short order: in 2007, MA was 20% of the program; today, it is over 50%.

In addition to MA, Medicare uses a capitation model to provide the prescription drug benefit, or Medicare Part D. As part of reforms in 2003, instead of providing the prescription drug benefit in the mold of traditional Medicare, Congress and the Bush administration opted for the privatized, MA-like capitated model.³⁵ Rather than directly reimbursing providers and pharmacies for drugs, Medicare would pay insurance companies to create prescription drug plans to offer to beneficiaries. The insurers, in turn, would pay pharmacy benefit managers (PBMs) to negotiate on their behalf. While there is no public option for comparison, Part D is infamous for having prohibited Medicare from negotiating prices after it approves a drug, fueling unparalleled prices for the drugs in the United States. Recently, the Biden administration took aim at this provision in a limited fashion, allowing Medicare to begin to negotiate for a select number of high-cost drugs. This modest reform is projected to save tens of billions in Medicare Part D over the next decade.³⁶

II. TRADITIONAL MEDICARE

While Republican policymakers have been the strongest advocates of MA and Part D, the Democratic Party has embraced the Capitation Consensus through recent reforms to traditional Medicare. In 2010 the Affordable Care Act (ACA) began to remake traditional Medicare in the image of MA, creating a flurry of capitation-based reimbursement models, often referred to as value-based care. These models were headlined by accountable care organizations (ACOs), a term first coined by Elliott Fisher of the Dartmouth Atlas.³⁷ The ACA established ACOs in the traditional Medicare program under the heading of the Medicare Shared Savings Program (MSSP) and established another office, known as the

32 Steve Lieberman and Paul Ginsburg, “Favorable Selection Ups the Ante on Medicare Advantage Payment Reform,” *USC Schaeffer*, June 13, 2023.

33 “Medicare Status Report,” pp. 354, *MedPAC*, March 2023; “Our Payments Their Profits,” Physicians for a National Health Program, October 4, 2023.

34 Richard Gilfillan and Donald M. Berwick, “Born On Third Base: Medicare Advantage Thrives On Subsidies, Not Better Care,” *Health Affairs*, March 27, 2023.

35 “An Overview of the Medicare Part D Prescription Drug Benefit,” Kaiser Family Foundation, October 17, 2023.

36 Juliette Cubanski, Tricia Neuman, and Meredith Freed, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” Kaiser Family Foundation, January 24, 2023.

37 *Id.*

Center for Medicare and Medicaid Innovation (CMMI), to facilitate other value-based financing experiments, including other forms of ACOs.

In ACOs and other value-based models, groups of physicians or hospitals become the financial risk-bearing entities. In this way, these models resemble health maintenance organizations (HMOs), which peaked in the 1990s, as well as many of the risk-bearing contracts that physicians enter into with MA insurance companies. In contrast to fee-for-service, value-based care models contain the familiar framework of the Capitation Consensus: Medicare establishes a risk- and quality-adjusted budget for a group of traditional Medicare patients who are “attributed” to the ACO, and the ACO profits if costs are kept below that budget.³⁸ Notably—and this is where parallels to MA and HMOs can cause confusion—most ACOs are still reimbursed under traditional Medicare on a fee-for-service basis, rather than receiving monthly capitated payments. At the end of the year, Medicare measures whether the ACO’s health spending is below what would be expected for the ACO’s patients; if it is, the ACO receives a share of the savings as profits. ACOs assuming “upside risk” face no consequences if aggregate spending is above the benchmark. By contrast, an ACO taking “downside” risk may have to pay money back to the government if total spending is sufficiently below their benchmark.

As noted, in addition to codifying the MSSP ACO program in statute and housing it in CMS’ Center for Medicare, the ACA established CMMI as the “innovation center” for value-based care experimentation. Since its inception, CMMI has rolled out dozens of capitation-based models. Some of these models have been variations on ACOs, such as the Pioneer ACO Model, which included more up-front capital for ACOs to invest in care transformation. In the Trump administration’s Direct Contracting model, CMMI more closely tried to emulate MA by experimenting with lump-sum capitated payments and more discretion for ACOs to constrict the network for beneficiaries. The Biden administration addressed numerous concerns about the Direct Contracting model and rebranded it ACO REACH. As another example of the push toward capitation-based models, CMMI recently began to move coverage for hospice care into the MA program, a benefit that has historically been retained in traditional fee-for-service Medicare.³⁹

Policymakers across the political aisle have taken additional steps since the ACA to reaffirm the Capitation Consensus within traditional Medicare. In 2015, as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress created an across-the-board 5% increase in the Medicare fee schedule for all providers who voluntarily enter capitation-based models, such as ACOs. As of 2021, roughly 42% of traditional Medicare patients were in ACOs and other “accountable care” relationships.

38 Tianna Tu et al., “Origins and Future of Accountable Care Organizations,” Leavitt Partners, May 2015.

39 “[VBID Model Hospice Benefit Component Overview](#),” Centers for Medicare & Medicaid Services, September 26, 2023.

Mostly recently, the Biden administration has announced its goal to have all traditional Medicare patients in an accountable care relationship by 2030.⁴⁰

Roughly a decade in, value-based care models within traditional Medicare are not the cost driver that is MA, in part because of tighter regulation. For example, Medicare ACOs cap the amount that a patient's risk score can grow over a contract period at 3%. The Medicare ACO program also prohibits the use of diagnostic codes from in-home risk assessments in calculating risk scores, which, as discussed later, is a pervasive tactic used in MA to increase capitated payments.⁴¹ In addition, there are no Star Rating bonuses, and, compared to MA, there are fewer selection issues, in which the risk-bearing entity selectively enrolls low-spending beneficiaries.

But at the same time, ACOs are still not delivering on the high hopes of cost saving envisioned by their early proponents. A 2023 report from the Office of Inspector General concluded that CMMI, the agency created to administer a range of value-based payment models, cost Medicare \$10 billion in its first decade of operation.⁴² The MSSP, which is the largest value-based program and is housed outside of CMMI, has also struggled to realize significant, if any, savings. Most favorably, the MSSP in 2022 saved Medicare \$1.8 billion, or 0.24% of Medicare spending, but these savings are measured against performance benchmarks, which do not represent counterfactual spending (nor do they purport to). A 2018 study found that physician-led Medicare ACOs were associated with savings of \$250 million annually, while hospital ACOs resulted in net losses.⁴³

Less favorably, a 2023 study examining MSSP performance between 2012 and 2021 found that the program was associated with net losses to traditional Medicare of \$584 million and \$1.4 billion. However, the study found that ACOs were associated with savings in MA, due to spillover effects.⁴⁴ This follows a study published in 2021 by researchers at the University of California San Francisco (UCSF), which found that all four CMS ACO programs from 2005 to 2018 “roughly broke even” for CMS.⁴⁵ In a 2022 report assessing the performance of the MSSP, MedPAC concluded that Medicare spending growth for beneficiaries in an MSSP treatment group was 1%-2% lower than it would have been if those patients were not in MSSP,⁴⁶ but MedPAC noted that it ignored bonus payments, which, if included as they were in the UCSF study, would limit or eliminate any savings.⁴⁷ Finally, other researchers

40 “Medicare ACO Participation Flat in 2022,” NAACOS, January 26, 2022.

41 “Policy Brief: Applying Risk Adjustment Caps in an Equitable Manner,” Aledade, January 27, 2023.

42 “Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid,” Congressional Budget Office, September 28, 2023.

43 Michael McWilliams et al., “Medicare Spending after 3 Years of the Medicare Shared Savings Program,” *New England Journal of Medicine*, September 20, 2018.

44 Andrew Ryan and Adam Markovitz, “Estimated Savings From the Medicare Shared Savings Program,” *JAMA Health Forum*, December 15, 2023.

45 James Kahn and Kip Sullivan, “Promise vs. Practice: the actual financial performance of Accountable Care Organizations,” *Journal of General Internal Medicine*, August 13, 2021.

46 “Assessing the Medicare Shared Savings Program’s effect on Medicare spending,” *MedPAC*, June 2019.

47 *Id.*

have focused on selection effects in ACOs, in which participating providers have built-in benchmark “tailwinds” that bake in savings irrespective of performance. These studies have found muted savings, or even losses.⁴⁸

III. MEDICAID

Though less the emphasis of this paper, Medicaid’s near-wholesale privatization over the last few decades further illustrates the force of the Capitation Consensus. Medicaid is larger, in terms of enrollees, than Medicare, covering roughly 90 million Americans, compared to Medicare’s 65 million. It costs roughly \$700 billion annually, relative to Medicare’s \$900 billion.⁴⁹ While the majority of enrollees are low-income adults and children, Medicaid pays for supplemental Medicare coverage for 12.5 million Americans and funds roughly 40% of nursing home care.⁵⁰ Known as “Medicaid managed care,” Medicaid privatization began to accelerate in the 1990s and continues today. Currently, 41 states have Medicaid managed care, and as of December 2022, 70% of Medicaid beneficiaries were enrolled in this privatized form of Medicaid. Five for-profit, publicly traded companies cover over half of the Medicaid managed care market: UnitedHealth Group (UnitedHealth), Elevance (formerly Anthem), Aetna/CVS, Centene, and Molina.⁵¹ In 2021, payments to Medicaid Managed Care Organizations (MCOs) totaled more than \$376 billion.

In Medicaid managed care, similar to MA, states pay a capitated payment to MCOs, which assume financial responsibility for enrollees. Medicaid capitated payments are typically modified based on risk adjustment and quality performance. Quality payments in Medicaid managed care operate in a variety of ways, including financial bonuses or penalties, or capitation “withholds,” in which the state retains a portion of the capitated payment unless and until the MCOs meet certain quality targets. Many states—14 as of 2021—are experimenting with Medicaid ACOs, in which Medicaid providers, such as physician practices, participate in capitation-based reimbursement models, assuming varying levels of financial risk. Some states directly contract with providers, similar to the Medicare ACO programs, while others allow or mandate their managed care organizations (MCOs) to develop ACO contracts with clinicians.⁵²

48 Mariétou H. Ouayogodé et al., “Estimates of ACO savings in the presence of provider and beneficiary selection,” *Healthcare*, March 2021; Adam Markovitz et al., “Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit,” *Annals of Internal Medicine*, June 18, 2019.

49 “NHE Fact Sheet,” Centers for Medicare & Medicaid Services, September 6, 2023.

50 Maria T. Peña, Maiss Mohamed, and Alice Burns, “Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals,” Kaiser Family Foundation, April 27, 2023.

51 Elizabeth Hinton and Jada Raphael, “A Closer Look at the Five Largest Publicly Traded Companies Operating Medicaid Managed Care Plans,” July 6, 2023.

52 Meredith B. Rosenthal et al., “Realizing the Potential of Accountable Care in Medicaid,” The Commonwealth Fund, April 12, 2023.

Despite the wholesale transformation of Medicaid in recent years, the evidence to support these changes is sparse. In the late 1990s, reformers were so bullish on the efficiency of managed care privatization that they projected significant budget-neutral coverage expansions.⁵³ However, there have been over 60 peer-reviewed studies over the past three decades analyzing the effects of Medicaid managed care; most have shown that managed care has had either no impact, or a negative impact, on cost and quality, while only a few have shown improvements.⁵⁴ According to Kathleen Adams, health economist and co-author of a 2022 literature review on Managed Medicaid, “research clearly says that the goal [of lower costs and better care] has not been reached.”⁵⁵ Further, an oft-touted benefit of managed care is that, even if it doesn’t save costs, states obtain budget predictability. But because managed care tends to include the subset of patients with the most predictable spending patterns, this benefit also seems to be oversold.⁵⁶

Nonetheless, states continue to move toward capitation-based financing in Medicaid. The one exception is Connecticut, which successfully reversed its managed care program in 2011. Costs went down; access to primary care, specialist physicians, and other providers increased; and the number of participating physicians went up 33%.⁵⁷

Taken together, health reform since the turn of the century has emphasized moving away from fee-for-service financing. As a result, the prevalence of capitation-based payment, especially in Medicare, has accelerated considerably. In 2012, 20% of Medicare beneficiaries were in a capitation-based payment model. Today, when combining the growth of both MA and ACOs, that number is over 70%. As discussed next, rather than fostering value in health care, the tidal shift toward capitation in publicly funded health care programs is fueling another wave of health care consolidation.

II. A NEW FRONTIER OF CONSOLIDATION

The under-told story of the Capitation Consensus is how it is transforming the provider ownership landscape. MA insurance companies and pharmacy retailers are purchasing providers and restructuring as vertically integrated conglomerates (“vertical conglomerates”). These acquisitions further the decades-long trend of corporate

53 Colleen Grogan, *Grow and Hide*, p. 322, Oxford University Press, 2023.

54 “Has Medicaid Managed Care Delivered On Its Promise?,” *Tradeoffs*, November 4, 2021.

55 “Has Medicaid Managed Care Delivered On Its Promise? Transcript,” *Tradeoffs*, November 4, 2021.

56 Victoria Perez, “Does capitated managed care affect budget predictability? Evidence from Medicaid programs,” *International Journal of Health Economics and Management*, October 14, 2017.

57 Joseph Burns, “Connecticut Bucks the Medicaid Managed Care Trend,” *Managed Healthcare Executive*, January 13, 2023.

consolidation in health care—the process of centralizing power in health care within large corporate entities and financial investors, rather than clinicians and patients.⁵⁸ As discussed in this part, this new form of consolidation is particularly profitable under capitation-based financing, but it poses risks for patients, clinicians, and the public.

MARKET OVERVIEW OF RECENT CONSOLIDATION

Recent trends in physician ownership reflect the rise of non-hospital corporate entities, such as vertical conglomerates and companies owned by private equity (PE). At the end of 2021, non-hospital corporate entities owned 27% of physician practices, an increase of 86% from three years prior.⁵⁹ After a flurry of transactions in 2022 and 2023, this percentage of practice ownership is likely higher today. In addition, a substantial amount of consolidation includes non-physician providers, such as in-home and post-acute providers, and pharmacies.

Capitation-based financing is supplying the capital and the incentive structure for these acquisitions. In 2023, the MA program was projected to make \$473 billion in payments, primarily to a handful of insurance companies: UnitedHealth (26%), Humana (18%), BCBS (14%), and CVS Health (11%).⁶⁰ In Medicaid, in 2021, payments to MCOs totaled more than \$376 billion, and five for-profit, publicly traded companies have over half of the Medicaid managed care market.⁶¹ And in traditional Medicare, ACOs and other value-based payment programs were projected to place another roughly \$175 billion “at risk,” which can only be captured by provider entities.

As recently stated by Andy Slavitt, the former EVP of Optum / UnitedHealth and head of CMS in the Obama administration, MA insurers are so flush with government money that they effectively have no choice but to buy up physicians to increase their valuations:

This [Medicare Advantage] is a business that generates a tremendous amount of cash, some might argue too much cash, and you either have to spend that cash to grow. ... So when you're generating literally billions, in the case of United, 25 billion in cash flow per year ... there's a growth imperative. ... So ... United was early to it ... but everyone is moving there because they see that is where the “risk dollars” are, and because they need to continue to grow.⁶²

58 Joe Bruch, Colleen Grogan, and Victor Roy, “The Financialization of Healthcare in the United States,” *New England Journal of Medicine*, January 11, 2024.

59 “PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021,” Physicians Advocacy Institute, April 2022.

60 Nancy Ochieng et al., “Medicare Advantage in 2023: Enrollment Update and Key Trends,” Kaiser Family Foundation, August 9, 2023.

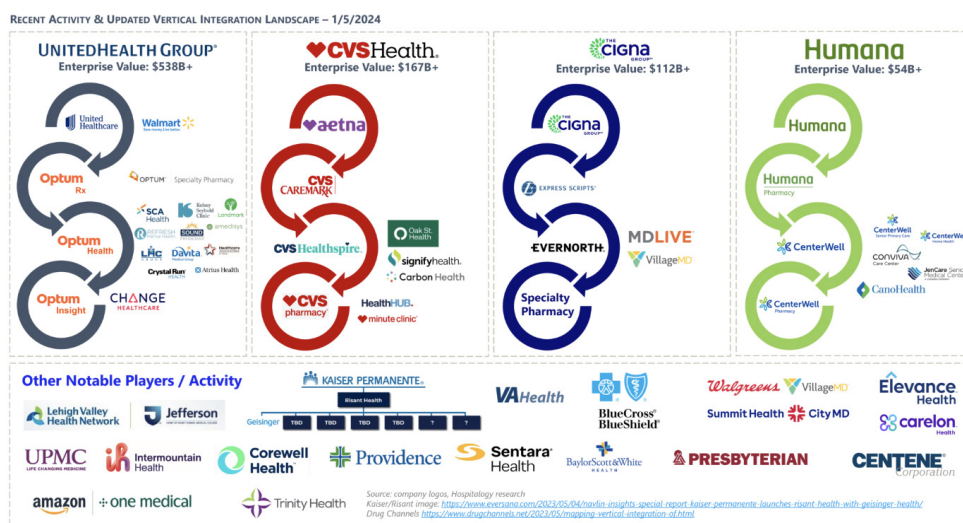
61 Elizabeth Hinton and Jada Raphael, “A Closer Look at the Five Largest Publicly Traded Companies Operating Medicaid Managed Care,” Kaiser Family Foundation, July 6, 2023.

62 Jacob Effron, “Optum's Evolution and Lessons from Obamacare and COVID: In Conversation with Andy Slavitt,” *Vital Signs*, April 18, 2023.

These vertical acquisitions are frequently framed as value-based care (VBC) investments. In primary care alone, it is estimated that \$50 billion has been invested by these corporate entities in recent years, with similar activity in home-based and post-acute care. And private equity is lubricating these rollups, increasing investment in VBC-aligned companies by more than 400% between 2019 and 2021. As one PE investor recently said, “All roads lead to Optum.”⁶³

The following market overview, summarized in Figure 1, illustrates the push to vertically consolidate. Vertical conglomerates see a population aging into Medicare and the commitment from policymakers to adopt capitation-based financing. In turn, they are restructuring to capture a greater proportion of capitation payments by owning more of the care delivery system and the drug supply chain.

Figure 1⁶⁴



UnitedHealth. As the leader in this space, UnitedHealth now comprises both the nation’s largest insurance company and the largest employer of physicians. Through Optum, UnitedHealth employs or is affiliated with over 90,000 physicians and 40,000 advanced practice providers (e.g., nurse practitioners) at more than 2,300 locations,⁶⁵ focusing on practices that operate in MA and across the range of capitation-based models (ACOs, Medicaid, and even ACOs in the commercial market).⁶⁶ Its bigger recent deals include a \$236 million acquisition of Atrius Health in 2022,⁶⁷ a network of over 600 primary care providers, and the \$4.6 billion acquisition of DaVita Medical Group in 2018, a network of

63 “Privatization in Health Care,” Senate Interim Committee on Health Care, September 26, 2023.

64 Blake Madden, “Vertical Integration Dominates the Payor Landscape,” *Workweek*, January 5, 2024.

65 Jakob Emerson, “Optum now has 90,000 physicians,” *Becker’s Payer Issues*, February 16, 2023.

66 Rylee Wilson, “15 things to know about ACO REACH,” *Becker’s Payer Issues*, February 23, 2023.

67 Susan Morse, “Massachusetts AG agrees to \$236 million Optum and Atrius Health merger,” *Healthcare Finance*, April 25, 2022.

300 clinics and their primary care physicians.⁶⁸ Signaling the growing consolidation and PE investment in behavioral health,⁶⁹ UnitedHealth bought PE-backed Refresh in 2020, a network of outpatient providers.⁷⁰ It also purchased AbleTo, a virtual behavioral health provider.⁷¹ In addition, UnitedHealth began its spree into specialty care with its 2017 purchase of Surgery Care Affiliates for \$2.3 billion, which it has rebranded SCA Health.⁷² It now owns over 320 surgery centers and brands itself as the leader of value-based specialty care—for example, operating as a convener for bundled payment models.⁷³

UnitedHealth is also moving into in-home care, with both primary and post-acute providers. In 2021, it bought PE-backed Landmark Health for \$3.5 billion and recently merged Landmark with Prospero Health, after acquiring it in 2022.⁷⁴ UnitedHealth also acquired LHC Group for \$5.4 billion in 2022 and is currently seeking to purchase Amedisys, a home health and hospice company, for \$3.3 billion.⁷⁵ These home-based assets complement UnitedHealth's 2020 purchase of PE-backed NaviHealth, which is one of a handful of post-acute “conveners” that have emerged within capitation-based models, particularly MA. Similar to PBMs on the drug side, conveners interface with both hospitals and insurance companies and attempt to manage post-acute spending, often by taking financial risk. NaviHealth has recently faced public scrutiny and is being sued for its use of algorithms to terminate or deny medically necessary but expensive care in skilled nursing facilities (SNFs).⁷⁶

On the prescription drug side, UnitedHealth is the owner of OptumRx, one of the three nationally dominant PBMs, which are middlemen in the drug supply chain that work on behalf of insurers to negotiate between drug manufacturers and pharmacies. In addition to being an insurer and a PBM, UnitedHealth also operates a mail-order pharmacy, a “specialty” pharmacy, and an in-person pharmacy for infusion therapies. In 2022, UnitedHealth entered into a 10-year “value-based care” arrangement with Walmart, which operates 5,000 pharmacies nationwide, now provides primary care in 27 clinics,⁷⁷ and is rumored to be the acquisition of MA-based primary care chain, ChenMed.⁷⁸ Finally, UnitedHealth also has a data and analytics services arm, OptumInsight, which recently

68 Ilene MacDonald, “Optum’s \$4.9B deal to buy DaVita Medical Group further expands UnitedHealth’s care delivery portfolio,” *Fierce Healthcare*, December 6, 2017.

69 Sharon Fry et al., “Global Healthcare Private Equity and M&A Report, Value-Based Care: Opportunities Expand,” Bain & Company, April 10, 2023.

70 Chris Larson, “UnitedHealth Group’s Optum Acquires Refresh Mental Health,” *Behavioral Health Business*, March 24, 2022.

71 “OptumHealth Names AbleTo Vet Trip Hofer CEO of Behavioral Health Solutions,” *Behavioral Health Business*, June 23, 2022.

72 Bob Herman, “UnitedHealth is on a buying spree of outpatient surgery centers,” *Stat News*, March 11, 2024.

73 Riz Hatton, “SCA Health grows to 320+ ASCs: 3 things to know,” *Becker’s Payer Issues*, July 10, 2023.

74 “Landmark Health Lands Investment From General Atlantic,” *Wall Street Journal*, March 28, 2018.

75 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

76 Casey Ross and Bob Herman, “UnitedHealth faces class action lawsuit over algorithmic care denials in Medicare Advantage plans,” *Stat News*, November 14, 2023.

77 “Walmart and UnitedHealth Group Collaborate To Deliver Access to High-Quality, Affordable Health Care,” Walmart, September 7, 2022.

78 Heather Landi, “Walmart exploring buying majority stake in primary care company ChenMed: media report,” *Fierce Healthcare*, September 11, 2023.

closed a controversial acquisition of Change Healthcare, the billing clearinghouse for the vast majority of medical claims in the nation. All told, UnitedHealth's Optum subsidiaries are now as much of a profit driver as their insurance arm.⁷⁹

Humana. As the second largest MA payer, Humana is now the nation's largest provider of Medicare-focused primary care, directly operating over 250 clinics nationwide.⁸⁰ In 2018, Humana rebranded its primary care practices as Conviva, which operates primary care practices as well as a management services organization (MSO) for over 300 affiliated practices operating in capitation-based contracts, such as MA and ACOs. In 2020, Humana began the first of two joint-venture investments with private-equity firm Welsh, Carson, Anderson & Stowe (WCAS) to build out another primary care practice chain, now called CenterWell. In 2022, the parties announced a second joint venture to deploy \$1.2 billion to open 100 new primary care practices between 2023 and 2025.⁸¹ Like Conviva, CenterWell has a management services arm, which operates in standard Medicare ACOs and now ACO REACH.⁸² Humana is in another joint venture with MA-based primary care practice, ChenMed, and it recently acquired numerous practices from CANO health, another practice chain that has long focused on MA and Medicare ACOs as both a direct provider and an MSO affiliate.⁸³

Humana has also been quickly moving into in-home and post-acute care.⁸⁴ In 2023, it launched an in-home primary care program through CenterWell, incorporating its acquisition of Heal, which focuses on in-home visits for the Medicare population. Humana became the largest home health provider with its \$5.7 billion purchase of PE-backed Kindred at Home in 2021.⁸⁵ Also in 2021, Humana purchased hospice provider Curo Health Services for \$1.4 billion, alongside investors WCAS and TPG Capital. As part of its "value-based care offerings," Humana also purchased PE-backed OneHome in 2021, which is now a vertically integrated conglomerate of home health agencies, infusion services, durable medical equipment, and pharmacies that also coordinates post-acute care for MA plans.⁸⁶ It is also a convener, similar to NaviHealth, and Humana has announced that it plans to have OneHome be the "coordinating agency" for half its own insurance members by 2027.⁸⁷ This acquisition of OneHome also bolstered Humana's pharmacy offerings, as well as its "In-Home Assessment" program, complementing its acquisition of Heal.

79 "UnitedHealth Group hits a milestone in vertical integration," Gist Healthcare, April 7, 2023.

80 "CenterWell Care Solutions," CenterWell Senior Primary Care, 2023.

81 "Humana's CenterWell Senior Primary Care and Welsh, Carson, Anderson & Stowe Announce Second Joint Venture to Develop and Operate Value-Based Primary Care Clinics for Medicare Patients," Humana, May 16, 2022.

82 "CenterWell Care Solutions," CenterWell Senior Primary Care, 2023.

83 "Cano Health sells substantially all of its Primary Care Centers in Texas & Nevada to CenterWell Senior Primary Care," *PR Newswire*, December 26, 2023.

84 Paige Minemyer, "Humana completes acquisition of Kindred at Home," Fierce Healthcare, August 18, 2021.

85 "Humana to buy out remaining stake in Kindred for \$5.7B," Fierce Healthcare, April 28, 2021.

86 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care," Center for Economic and Policy Research, September 26, 2023.

87 *Id.*

CVS Health. The recent investment activity of CVS Health also illustrates the vertical consolidation occurring under the Capitation Consensus. For CVS, like all these corporate investors, entering and growing in the MA market as a payer and provider is the highest priority, while other capitation models, such as ACOs, layer on synergies. CVS' biggest move as a capitation-based conglomerate came in 2018 with its acquisition of Aetna, the nation's third-largest MA insurance company. This immediately complemented its pharmacies, its PBM, Caremark, and its network of 1,100 light-touch MinuteClinics.⁸⁸

In 2023, CVS moved into traditional and home-based primary care. It purchased Oak Street Health for \$10.6 billion, then a chain of roughly 170 Medicare-focused primary care practices across 21 states.⁸⁹ In 2024, it plans to build more than 50 clinics and expand its footprint to 25 states.⁹⁰ Similar to Optum and Humana clinics, and affiliates such as ChenMed and CANO, Oak Street was developed in close alliance with MA payers and now also operates in Medicare's ACO program and ACO REACH. In addition to Oak Street, CVS also purchased private-equity-backed Signify for \$8 billion, which, like Humana's Heal and UnitedHealth's "House Calls" programs, specializes in MA-based home visits to risk code patients.⁹¹

The Signify and Oak Street acquisitions fueled CVS' continued investment in the ACO business in 2023. Prior to selling to CVS, Signify had purchased Caravan Health, an MSO that operates Medicare ACOs with affiliate practices, for \$250 million. At the end of 2023, CVS announced "CVS Accountable Care," combining Caravan with Oak Street and its existing ACO REACH business and ACO MSO partnerships. CVS Accountable Care is managing \$10 billion and 1 million patients.⁹²

Cigna. Like UnitedHealth, insurance conglomerate Cigna also contains the prescription drug trifecta as an insurer, a PBM, and a pharmacy. It owns the third of the "big three" PBMs, Express Scripts, as well as the specialty pharmacy Accredo. Cigna also owns and invests in provider care assets through its subsidiary, Evernorth. Evernorth has been focused on behavioral health, including its telehealth platform, MDLIVE.⁹³ It also made a \$2.5 billion investment in VillageMD, a senior-focused primary care chain now majority owned by Walgreens (more below).⁹⁴ Cigna, which has a larger presence in commercial insurance than Medicare, recently sold its MA business to Health Care Service Corporation

88 Id.

89 Heather Landi, "CVS closes \$10.6B acquisition of Oak Street Health to expand primary care footprint," Fierce Healthcare, May 2, 2023.

90 Bruce Japsen, "CVS To Build More Than 50 Oak Street Senior Clinics In 2024," *Forbes*, August 2, 2023.

91 Robert King, "CVS closed \$8B deal for health services company Signify Health," Fierce Healthcare, March 29, 2023.

92 "CVS Health Investor Day 2023," CVS, December 2023.

93 Chris Larson, "What Potential Humana-Cigna Tie Up Means for Behavioral Health," Behavioral Health Business, November 9, 2023.

94 Bruce Japsen, "Cigna's \$2.5 Billion Stake In VillageMD's Summit Venture To Grow Evernorth Provider Portfolio," *Forbes*, November 8, 2022.

for \$3.7 billion.⁹⁵ Signaling a complete crossover to the provider and prescription drug side, Cigna explained that it will focus its Medicare investments in Evernorth.

Walgreens. Walgreens is quickly mimicking CVS Health’s vertical consolidation efforts. In 2021, Walgreens made a \$5.2 billion investment in VillageMD “to advance its strategic position in the delivery of value-based primary care, a \$1 trillion, fast-growing segment of the healthcare system.”⁹⁶ It now has a majority stake, while Cigna is a minority owner. VillageMD declared plans to scale from 230 practices in 2021 to 1,000 in 2027, although it recently announced a spate of closures.⁹⁷ Last year VillageMD purchased Summit Health for \$9 billion, which was one of the largest independent physician groups, operating 680 provider locations.⁹⁸ Walgreens also moved into post-acute and home care in 2021, acquiring CareCentrix, a home health convener that manages 19 million members through over 7,400 provider locations.⁹⁹ As of September, Walgreens purchased Pearl Health, a tech-focused aggregator of primary care practices that is focused on ACO REACH, with ultimate plans to move into MA.¹⁰⁰

Amazon. Amazon’s latest foray into health care targets pharmacy services and primary care. It purchased PillPack in 2020, an online pharmacy, and it recently launched Amazon clinic, a platform for low-acuity virtual care. In 2022, Amazon purchased the primary care chain, One Medical. Prior to the acquisition, One Medical had bought Iora Health, another MA-based primary care company, for \$2.1 billion.¹⁰¹ At the time of Amazon’s acquisition, One Medical was booking half its revenue from Iora, primarily from capitation contracts with MA payers, as well as Medicare ACOs and ACO REACH.¹⁰²

Other Players. Finally, Medicaid insurers and hospital systems are also pursuing a vertical integration playbook under capitation. Elevance (previously Anthem), which is the second largest Medicaid plan, has recently built out its provider subsidiary, Carelon. It now provides palliative care, behavioral health, and home-based care, including another large post-acute convener, myNEXUS.¹⁰³ It also owns a PBM and recently signaled its plans to invest more heavily in primary care.¹⁰⁴ Centene, the largest Medicaid insurer, acquired Community Medical Group, a large risk-based practice in Florida, in 2018; in 2022, Centene made further investments in CMG with the goal of bringing the model to other

95 Paige Minemyer, “Cigna inks deal to sell Medicare business to HCSC for \$3.7B,” *Fierce Healthcare*, January 31, 2024.

96 “Walgreens Boots Alliance Makes \$5.2 Billion Investment in VillageMD to Deliver Value-Based Primary Care to Communities Across America,” *Walgreens*, October 14, 2021.

97 *Id.*

98 Blake Madden, “VillageMD Ties The \$9 Billion Knot With Summit Health,” *Hospitality*, November 7, 2022.

99 *Id.*

100 Heather Landi, “Pearl Health clinches \$75M backed by a16z to scale up value-based care tech,” *Fierce Healthcare*, January 30, 2023.

101 Paige Minemyer, “One Medical to acquire Iora Health in \$2.1B all-stock deal,” *Fierce Healthcare*, April 28, 2021.

102 Soleil Shah, Hayden Rooke-Ley, and Erin Fuse Brown, “Corporate Investors in Primary Care — Profits, Progress, and Pitfalls,” *New England Journal of Medicine*, January 12, 2023.

103 “Anthem, Inc. To Acquire myNEXUS, Home Health Benefits Manager,” *Business Wire*, March 24, 2021.

104 Kate Fisher and Dan Stanek, “Payviders’ Moving to the Front Door of Healthcare,” *Wayfind*, 2023.

markets.¹⁰⁵ As for hospitals, a recent survey found that 60% of hospital systems reported that they planned to become MA plans in 2022.¹⁰⁶ This trend is highlighted by the recent merger between Geisinger Health, a large hospital system, and Kaiser, which now has 6% of the MA market.¹⁰⁷ Other large integrated systems include UPMC in Pennsylvania, and Providence Health in the Northwest.

RISKS OF VERTICAL CONSOLIDATION UNDER CAPITATION-BASED MODELS

Consolidation allows these vertical conglomerates to use capitated payment structures in ways that drive profits without creating value. As noted above, corporate consolidation in health care has existed for decades, largely driven by hospitals. The primary result: hospitals can negotiate higher prices in the commercial market, cut labor costs and demand more of clinicians, and exploit various loopholes in the fee-for-service Medicare system.¹⁰⁸ In addition, private equity (PE) rollups in health care have risen dramatically over the decades, also exploiting fee-for-service reimbursement and threatening patient care.¹⁰⁹

Today, as policy moves away from fee-for-service, analogous patterns of corporate consolidation are emerging under capitation-based financing. While vertical conglomerates promise clinical integration, familiar harms are emerging, such as the push toward “productivity” medicine and the replacement or supplementation of physicians with less expensive advanced practice providers.¹¹⁰ Moreover, as detailed below, consolidation under capitation presents a new set of risks, centered on payment gaming, patient steering, and anti-competitive coordination between sister subsidiaries of the same parent company.

I. GAMING CAPITATED BENCHMARKS

Vertical conglomerates in capitation-based models are keen on controlling primary care physicians, who are essential for inflating risk-adjustment payments and quality

105 Paige Minemyer, “[Here’s how Centene is thinking about M&A as it tackles its value creation plan](#),” Fierce Healthcare, May 11, 2022.

106 Robert King, “[Nearly 60% of health systems aim to become ‘payviders’ in 2022, survey finds](#),” Fierce Healthcare, November 9, 2021.

107 Nancy Ochieng et al., “[Medicare Advantage in 2023: Enrollment Update and Key Trends](#),” Kaiser Family Foundation, August 9, 2023.

108 Karyn Schwartz, Eric Lopez, Matthew Rae, and Tricia Neuman, “[What We Know About Provider Consolidation](#),” Kaiser Family Foundation, September 2, 2020; Corey Capps et al., “[The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending](#),” Northwestern Institute for Policy Research, February 2015 (concluding that vertical integration was associated with a 13.7% increase in physician prices); Sylvia A. Allegretto and Dave Graham-Squire, “[Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages](#),” Center for Economic and Policy Research, January 5, 2023; Jessica Silver-Greenberg and Katie Thomas, “[They Were Entitled to Free Care. Hospitals Hounded Them to Pay](#),” *New York Times*, December 22, 2022; Christopher Whaley, Sebahattin Demirkan, and Ge Bai, “[What’s behind losses at large nonprofit health systems?](#)” *Health Affairs Forefront*, March 24, 2023.

109 Anaeze C. Offodile II et al., “[Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17](#),” *Health Affairs*, May 2021; Atul Gupta et al., “[How Patients Fare When Private Equity Funds Acquire Nursing Homes](#),” NBER, August 2023.

110 Joseph Dov Bruch et al., “[Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices](#),” *Health Affairs*, January 2023.

bonuses. In MA alone, gaming of risk adjustment is responsible for at least \$23 billion in annual overpayments to insurers, while quality payments amount to another \$10 billion in subsidization without demonstrated value.¹¹¹ In addition to increasing costs, the preoccupation with risk-coding and box-checking wastes scarce time with patients and contributes to dissatisfaction among clinicians.

As explained in Part I, in capitation-based financing, the government modifies payments to risk-bearing entities, such as MA insurers and ACOs, based on the estimated disease severity of patients. This is intended to discourage favorable selection, in which risk-bearing entities enroll mainly “healthy” patients who systematically incur lower-than-average medical expenditures. In addition to fixed demographic factors, a patient’s “risk score” is determined by the number and severity of clinical diagnoses that are communicated to the government. The arbitrage opportunity exists because patients in fee-for-service have not been maximally “coded.” When patients move into MA, insurers and providers drastically increase their risk scores, often by more than 20%.¹¹² In concrete terms, a patient with a risk score of 1.0 is given an annual Medicare “budget” of roughly \$10,000. If that patient’s risk score is 1.2, the insurance entity now has a \$12,000 budget, per patient, against which to make a profit.

Risk coding has become a significant area of abuse under capitation-based financing. All of the ten largest MA companies have been accused of fraud by a whistleblower or the US government.¹¹³ Similar allegations were recently made against one of the largest ACO companies in a whistleblower suit.¹¹⁴ One form of fraud is through the retrospective addition of diagnosis codes. For example, a whistleblower case that was brought and settled against Sutter Health, a California MA plan, alleged that Sutter and its affiliate providers were inaccurately coding conditions as chronic, rather than acute, and that they were employing a “pit crew” to go behind the physician to add diagnoses to patient records after the encounters.¹¹⁵ Recent reporting from a UnitedHealth clinic depicted the same process facilitated by nurses and billers.¹¹⁶

Moreover, ownership of practices allows vertical conglomerates to embed technology, workflows, and compensation structures that maximize coding. For example, the lawsuit against Sutter alleged that managers were pressuring physicians to add codes by sending

111 Steven M. Lieberman, Paul Ginsburg, and Samuel Valdez, “[Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments](#),” USC Schaeffer, June 13, 2023; Laura Skopec and Robert Berenson, “[The Medicare Advantage Quality Bonus Program](#),” Urban Institute, June 2023.

112 Michael Geruso and Timothy Layton, “[Upcoding: Evidence from Medicare on Squishy Risk Adjustment](#),” *Journal of Political Economy*, March 2020; Fred Schulte, “[Researcher: Medicare Advantage Plans Costing Billions More Than They Should](#),” *Kaiser Health News*, November 11, 2021.

113 Reed Abelson, “[‘The Cash Monster Was Insatiable’: How Insurers Exploited Medicare for Billions](#),” *New York Times*, October 8, 2022.

114 Fred Schulte, “[Whistleblower Accuses Aledade, Largest US Independent Primary Care Network, of Medicare Fraud](#),” *KFF Health News*, March 5, 2024.

115 “[United States’ Complaint-In-Intervention](#),” *United States of America ex rel. Kathy Ormsby v. Sutter Health*, March 4, 2019.

116 Adam Stone, “[Whistleblower Releases Audio, Files Complaint: Cites Medical Billing Plot at Optum](#),” *The Examiner*, March 18, 2024.

them algorithmically generated daily alerts suggesting missed codes for MA patients. They were also accused of pre-populating patient records with codes and meeting with physicians one-on-one to encourage them to add codes to their patient records. At UnitedHealth practices, as with Sutter, the medical record is pre-populated with codes for each visit, and the clinician is barred from closing the note until all the suggested codes are addressed. Further, managers reportedly confront clinicians to inquire about missing codes and require that they attend mandatory coding training, rather than seeing patients.¹¹⁷

Another coding practice, as the Office of Inspector General recently documented, is in-home health risk assessments (HRAs).¹¹⁸ Here, clinical providers will visit the home to gather information about the patient's health status and document diagnoses for risk adjustment. Vertical conglomerates are therefore building and purchasing companies specifically devoted to this practice.¹¹⁹ These include UnitedHealth's "House Calls" program, CVS Health's purchase of Signify, and Humana's acquisition of Heal and OneHome. Notably, Medicare ACOs do not allow in-home HRAs to contribute to risk coding, and for traditional Medicare patients who are not in capitation-based models, there is no financial advantage to risk coding. As a result, a recent Health Affairs study found that an annual home visit was 31 times more likely to occur in MA than traditional Medicare.¹²⁰

The centrality of data in diagnosis coding puts vertical conglomerates in the driver's seat. It helps contextualize UnitedHealth's recent \$13 billion acquisition of Change Healthcare, the nation's largest billing clearinghouse, which, according to the Department of Justice, would give UnitedHealth a near monopoly (94% market share) over the clearinghouse market.¹²¹ Through the prism of risk coding, as well as other financial strategies discussed below, the business case was obvious: acquiring Change gives UnitedHealth visibility into the claims, diagnosis codes, and provider IDs of tens of millions of patients.

Beyond risk adjustment, the quality component of capitation-based payments appears to be subject to similar gaming as risk-coding. Under MA's quality payment program (QPP), or Star Rating program, Medicare made bonus payments amounting to \$10 billion in 2022, even though MedPAC and other researchers concluded that care quality and care

117 Interview with anonymous Optum physician.

118 "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments," Office of Inspector General, September 20, 2021.

119 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care," Center for Economic and Policy Research, September 26, 2023.

120 Jeffrey Marr et al., "Home-Based Medical Care Use In Medicare Advantage And Traditional Medicare In 2018," *Health Affairs*, September 2023.

121 Amy Y. Gu, "DOJ's Challenge of the UnitedHealth and Change Healthcare Merger: What Went Wrong and What Does it Mean?," *The Source*, October 17, 2022.

improvement is largely uncorrelated with MA Star Rating performance.¹²² Nonetheless, MA plans receive a bonus of 5% on their total capitated payments if they receive four stars, accounting for 4%-5% of earnings for some major MA plans.¹²³

As with risk adjustment, vertical conglomerates can inflate quality scores with greater control of clinicians. They can, for example, game medication adherence quality measures by pushing providers to put their patients on 90-day refills, mail-order prescriptions, and automatic refills, even if patients never take the medications. Similarly, they can discourage or prohibit clinicians from giving samples to patients and allowing them to use lower-cost alternatives.¹²⁴ Further, Star Ratings and other quality programs require significant administrative efforts, placing small practices at a disadvantage. Staff at primary care practices have entire teams devoted to tracking and managing performance. They must mine the fragmented health care system for paperwork or records proving that a given test was administered, and then report this documentation through a unique software portal for Medicare or the private insurance company.¹²⁵ For vertical conglomerates, the burden on smaller practices creates an acquisition opportunity.

These two arbitrage opportunities—risk scoring and quality gaming—illustrate the obvious business case for vertical consolidation of primary care and in-home providers. Already, abuse of risk adjustment and quality programs is causing tens of billions in subsidies, further supplying the capital for provider acquisitions. With greater ownership and control of providers, vertical conglomerates can reproduce overpayments in MA and employ the same tactics as the risk-bearing entity in ACOs. Beyond fiscal waste, these financial strategies divert from scarce time in the exam room, undermining patient care and driving clinician burnout.¹²⁶

II. PATIENT STEERING AND “CAPTIVE” REVENUE

Next, consolidation allows vertical conglomerates to steer revenue to their sister subsidiaries, such as primary and specialty care, post-acute care, and pharmacies. This not only enables them to skirt federal regulations intended to cap profits; it also drives out independent providers and allows conglomerates to steer patients away from expensive yet medically necessary care.

122 Jeannie Fuglesten Biniak, Anthony Damico, and Tricia Neuman, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” Kaiser Family Foundation, August 9, 2023; Laura Skopec and Robert Berenson, “The Medicare Advantage Quality Bonus Program,” Urban Institute, June 2023; “The Medicare Advantage program: Status report,” MedPAC, March 2023.

123 “2023 Medicare Advantage and Part D Star Ratings,” Center for Medicare and Medicaid Services, October 6, 2022; Blake Madden, “CVS, Oak Street, and the Great Payor Vertical Integration War,” *Workweek*, February 9, 2023.

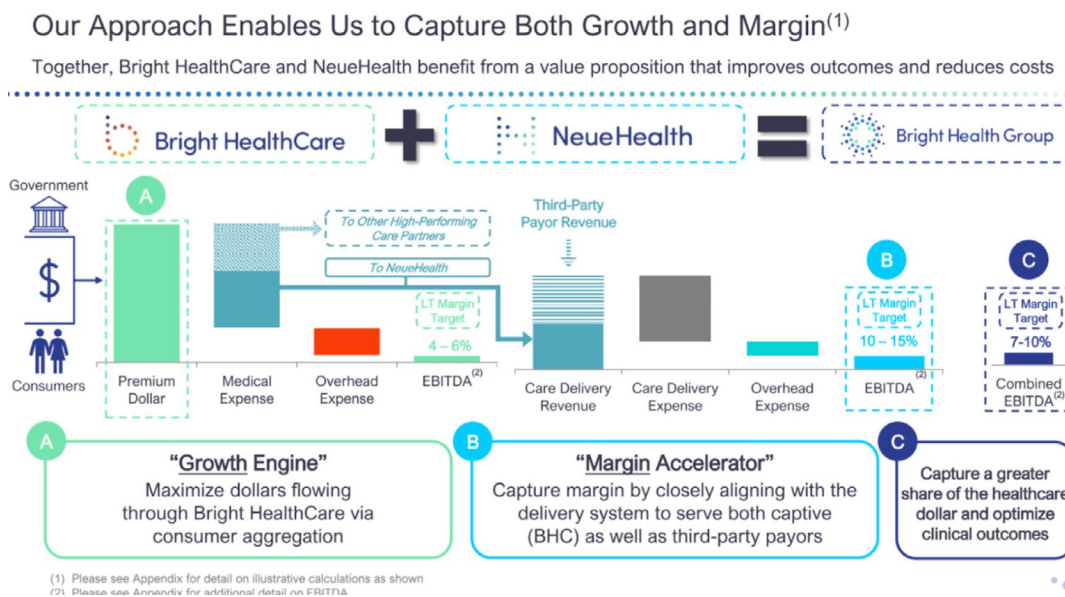
124 C. Annette DuBard et al., “Why The Star Ratings Medication Adherence Measures Must Go,” *Health Affairs*, January 10, 2024.

125 Kelsey Waddill, “The Fundamentals of Medicare Advantage Star Rating Methodology,” *Health Payer Intelligence*.

126 Noam Scheiber, “Why Doctors and Pharmacists Are in Revolt,” *New York Times*, December 23, 2023.

Steering care generates “captive revenue” for vertical conglomerates.¹²⁷ Bright Health, an MA insurance company that recently sold to Molina, depicted this strategy to investors. As shown in Figure 2, insurers see provider ownership as the “margin accelerator.” This is because ownership of the practice unlocks revenue from all third-party payers (i.e., other insurance companies and government payers with patients served by that provider), and it allows the insurance companies to retain more of their capitation payments through captive revenue.

Figure 2



UnitedHealth is increasingly relying on this captive revenue—or “intercompany eliminations”—with its growth of its provider subsidiary, Optum. UnitedHealth has increased intercompany eliminations by over 80% in five years, reaching \$108 billion in 2022.¹²⁸ It now sends over 25% of its medical claim revenue to its own subsidiaries.¹²⁹ Its market presence shows why: UnitedHealth exists in 87% of insurance markets, only rivaled by Humana at 90%.¹³⁰ Further, UnitedHealth has over 50% share in more than 140 MA markets.¹³¹

These captive revenue strategies enable regulatory arbitrage. Medical Loss Ratios (MLRs) were established in the Affordable Care Act to cap insurance administrative costs and profits and to ensure that a minimum percentage of capitation payments and private

127 Joe Connolly, “This graphic shows...,” X, July 14, 2021.

128 “UnitedHealth Group hits a milestone in vertical integration,” Gist Healthcare, April 7, 2023.

129 Editorial Board, “Elizabeth Warren Has an ObamaCare Epiphany,” *The Wall Street Journal*, November 24, 2023.

130 Meredith Freed, “Medicare Advantage 2024 Spotlight: First Look,” Kaiser Family Foundation, November 15, 2023.

131 “TCF Analysis Shows UnitedHealthcare Holds 50% or Greater Share in 140 Medicare Advantage Markets,” *The Capitol Forum*, September 18, 2023.

insurance premiums were spent on medical care. However, insurance companies can circumvent this regulation by paying themselves, directing above-market payments and end-of-year bonuses to their own sister subsidiaries. This is referred to as “transfer pricing” and has been best documented with PBMs.¹³² For example, UnitedHealth can evade the MLR requirement by paying higher-than-cost fees to its Optum PBM, booking that fee as a medical cost.¹³³ The same is possible with medical providers: insurers can increase fees to their sister primary care or post-acute providers to conceal profits as costs and to therefore evade the MLR constraint.¹³⁴

In addition to increasing profits, steering squeezes independent providers and other competitors. In the prescription drug space, the gaming of medication adherence, explained above, diverts business away from unaffiliated pharmacies while gaming quality metrics. As another example, vertical conglomerates that own PBMs can devise formularies and copays that funnel patients to their own pharmacies, squeezing independent pharmacies.¹³⁵ The proliferation of “specialty” pharmacies embeds these anti-competitive practices. Vertical conglomerates, all of which now own specialty pharmacies, increasingly require that certain drugs be dispensed through this alternative channel. Specialty pharmacies now account for over half of prescription drug spending. Another concern is on the prescriber side. As conglomerates own more providers, such as traditional primary care offices and MinuteClinics, they can configure prescribing technology and workflows to favor their own pharmacies, even if cheaper options exist for independent pharmacies.

Vertical consolidation in the post-acute setting presents similar steering risks. MA insurers have increasingly been under scrutiny for limiting or denying care through narrow networks, “ghost networks,” and onerous prior authorization.¹³⁶ Recent reporting revealed that UnitedHealth and Humana are using artificial intelligence with their conveners, specifically NaviHealth, to drive “clinical” prior authorization decisions and override clinical judgment.¹³⁷ This NaviHealth scandal is part of a larger vertical consolidation story. Vertical conglomerates are rapidly consolidating conveners, such as NaviHealth and OneHome, which focus on diverting care from the hospital and skilled nursing facilities. This reduces costs for their insurance subsidiaries, and it also drives revenue to home-based providers that they own, again generating “double margins” for the parent company.

132 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

133 Richard Frank and Conrad Milhaupt, “Profits, medical loss ratios, and the ownership structure of Medicare Advantage,” Brookings, July 13, 2022.

134 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

135 Eric Elliott, “Why Independent Pharmacies Remain a Pillar for Access, Community Health,” *Pharmacy Times*, June 30, 2023.

136 Jakob Emerson, “Hospitals are dropping Medicare Advantage plans left and right: 13 updates,” *Becker’s Hospital CEO Report*, November 16, 2023; “Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks,” Senate Committee on Finance, May 3, 2023.

137 Elizabeth Napalitano, “UnitedHealth uses faulty AI to deny elderly patients medically necessary coverage, lawsuit claims,” *CBS News*, November 20, 2023.

Another way to steer patients in post-acute care is to effectively bring the prior authorization function “in house.” By directly employing physicians, the risk-bearing entity can cut costs by prohibiting or discouraging clinicians from authorizing expensive care. In a 2020 whistleblower lawsuit reported by The Prospect, Maxwell Ollivant, a UnitedHealth-employed nurse practitioner in a nursing home, alleged that his supervisor denied requests to transfer UnitedHealth-MA patients with exacerbations to the hospital.¹³⁸ This, Ollivant alleged, was consistent with UnitedHealth’s compensation structure, which gave bonuses to their clinicians who kept patients in the nursing home and out of the hospitals.¹³⁹

Taken together, these steering practices will look familiar to antitrust observers across sectors. Amazon, for example, will steer customers to purchase its own goods on its marketplaces by preferentially placing those products under search queries.¹⁴⁰ Similarly here, vertical conglomerates, like the Amazon marketplace, are directing business to their own products, such as pharmacies and physician practices. As depicted above, however, this captive revenue strategy carries grave risks.

III. PATIENT “FLIPPING” AND ENROLLMENT ARBITRAGE

Consolidation also provides vertical conglomerates with powerful leverage to “flip” patients into their insurance plans and ACOs, a more extreme version of the steering documented above. In addition to increasing overall enrollment, flipping gives conglomerates a tool to drive “favorable selection,” or the practice of enrolling patients who are systemically profitable, even after risk-adjustment. In MA, favorable selection is responsible for another 11%-14% of overspending, or as much as \$56 billion annually.¹⁴¹ Selecting enrollees also allows insurers in MA to game county benchmark bonuses, which excessively rewards insurers with patients in areas of low Medicare spending, to the tune of another roughly \$10 billion in excess MA payments.¹⁴² As vertical conglomerates increasingly own physicians and operate in ACOs, similar risks of selection may arise.¹⁴³

With vertical consolidation, conglomerates can capitalize on more touch points to patients. For example, CVS Health has recently launched initiatives to increase MA and ACO enrollment by targeting specific patients at specific CVS pharmacies. The goal is to sell them on an in-home evaluation or a visit to CVS’ primary care office, which will boost the patients’ risk scores and increase the likelihood of enrollment in their insurance plan

138 “[Complaint](#),” *United States of America, et al. ex rel. Maxwell Ollivant, v. Optum, UnitedHealth Group*, May 13, 2020.

139 *Id.*

140 Julie Creswell, “How Amazon Steers Shoppers to Its Own Products,” *New York Times*, July 23, 2018.

141 Steve Lieberman and Paul Ginsburg, “[Favorable Selection Ups the Ante on Medicare Advantage Payment Reform](#),” USC Schaeffer, June 13, 2023.

142 “[Our Payment Their Profits](#),” Physicians for a National Health Program, October 4, 2023.

143 Adam Markovitz et al., “[Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit](#),” *Annals of Internal Medicine*, June 18, 2019.

(Aetna) or their ACO.¹⁴⁴ As another example, practice ownership allows conglomerates to send representatives to do “Medicare 101” information sessions in the clinic. Ostensibly, these representatives neutrally educate elderly patients on their Medicare options, but they are paid on commission for each patient they enroll.

More direct than marketing, provider acquisitions allow conglomerates to “flip” patients into MA plans or ACOs by coordinating efforts with sister provider subsidiaries. Conglomerates can initiate the flipping strategy by using some of the steering tactics discussed above.¹⁴⁵ In a recent lawsuit, UnitedHealth was accused of terminating contracts with unaffiliated physicians in order to force the patients to establish care at nearby Optum practices.¹⁴⁶ In another suit, UnitedHealth, with 50% of the MA and commercial insurance markets, allegedly attempted to force the sale of local practices to Optum. UnitedHealth was accused of cutting insurance reimbursement and steering members away from the target practice, and as a condition of insurance contracting, forcing the target practice to give UnitedHealth the first right of refusal upon sale.¹⁴⁷

Once the physician group is acquired by the vertical conglomerate, it can contract exclusively with the sister insurance subsidiary.¹⁴⁸ Patients who want to continue seeing those physicians are all but forced to be part of the MA plan or other capitation model. Short of such exclusive contracting, the conglomerate can achieve a similar objective by contracting less favorably with other insurers. Another tactic is to begin rejecting traditional Medicare patients and only accept MA, undermining the bedrock open-network guarantee of Medicare.

Consolidation of health care data infrastructure, such as the Change-UnitedHealth merger, elevates concerns about enrollment and selection arbitrage. Already, insurers possess troves of information with which to identify prospective patients. As 10,000 Americans age into Medicare daily, vertical conglomerates can leverage their data across lines of business to target practices with profitable patients.¹⁴⁹ Similarly, with greater ability to select their enrollees, they can exploit the aforementioned bonuses provided to plans in low-spending geographies.

These flipping and selection strategies again extend beyond fiscal waste. As with the broader harms of the new frontier of consolidation, patients and clinicians experience

144 Blake Madden, “CVS Health Bets the House,” *Workweek*, August 10, 2023; “Weekly Health Tech Reads,” Health Tech Nerds, December 10, 2023.

145 Brittany Trang, “Antitrust lawsuit alleges UnitedHealth’s Optum pressured a California hospital to stop competing over physicians,” *Stat News*, November 23, 2023.

146 “An insurance titan is dropping hundreds of N.J. physicians to enrich itself, doctors and patients charge,” *NJ.com*, February 2023.

147 Brittany Trang, “Antitrust lawsuit alleges UnitedHealth’s Optum pressured a California hospital to stop competing over physicians,” *Stat News*, November 23, 2023.

148 Blake Madden, “CVS, Oak Street, and the Great Payor Vertical Integration War,” *Workweek*, February 9, 2023.

149 “Complaint,” *U.S. and Plaintiff States v. UnitedHealth Group, Inc. and Change Healthcare Inc.*, February 24, 2022.

fewer and worse options, and more control in health care is centralized within large vertically integrated conglomerates.

III. TOWARD HEALTH CARE INDUSTRIAL POLICY

Addressing emerging consolidation—as well as analogous trends in the hospital context—will require moving beyond the Capitation Consensus. As discussed in Part I, capitation-based financing relies on private-sector utilization management to improve value. In theory, properly incentivized insurance companies and risk-bearing providers will profit by managing the population’s use of services, generating lower-cost, high-quality care. However, as the foregoing parts demonstrate, adopting capitation-based models is not delivering on cost-saving promises—and the MA program in particular has become a substantial cost driver. Instead, the Capitation Consensus is transforming the provider landscape, fueling a new frontier of corporate consolidation.

An alternative policy paradigm would orient around health care “industrial policy,” joining the post-neoliberal thinking across other policy domains.¹⁵⁰ This approach would emphasize at least three principles, briefly outlined here. First, it would combat consolidated corporate power and promote the autonomy and collective power of clinical providers. Health policy has long been solicitous of integration, without proper attention to the costs of market power to patients and the health care workforce. The anemic response to decades of hospital consolidation counsels for swift action today against obvious forms of vertical consolidation, even if it is framed as “value-based care” or “alignment.” This approach would also be attentive to the relationship between privatization of public programs and the creation of corporate behemoths, such as today’s MA conglomerates.

A second principle would revive concerns about the ownership structure and governance of health care providers, understanding how control by clinicians and the public can shape the ethical valence of care delivery. This approach would challenge a core conceit of the Capitation Consensus—that physicians and other medical professionals are cold economic actors, just like corporations and investors, whose for-profit incentives merely need proper channeling. The emerging harms of vertical consolidation within capitation-based models illustrate the limits of economic incentivization to produce policy outcomes.

150 K. Sabeel Rahman, “Saving Bidenomics,” *Boston Review*, January 4, 2024; Amy Kapczynski and Joel Michaels, “Administering a Democratic Industrial Policy,” *Harvard Law & Policy Review*, forthcoming.

Such an outlook, which blurs the competing loyalties of business and patient care, may ultimately reduce medical providers to financial instruments, with the “asset” of a patient panel and the capacity to practice “productivity” medicine. Regulation of ownership structure and governance is also critical for minimizing gaming and other financial tactics that are unconnected to patient care. Fully formulated, this policy approach would allow policymakers to rely less on private-sector utilization management to contain costs and instead apply tenets of public utility law to regulate prices, profits, and private-sector administrative bloat.¹⁵¹

A third principle would focus on the “supply side”: how policymakers can exercise greater control over public money and rationally dictate how we produce and allocate capacity in the system. By embracing the government’s central role in designing the system—taxpayers now finance nearly 70% of the health care economy—policymakers can increase the supply of clinicians and redistribute them towards areas of underinvestment, like primary care. In addition to labor, similar thinking is needed in capital policy—our system of allocating and financing infrastructure like clinics and hospitals, which is another area of significant state subsidization with little rational organization. In addition, strengthening control over public money would revive once-lively debates about direct public provisioning of care and direct financing of capital projects.

The following recommendations seek to roll back the harms of the Capitation Consensus and build toward alternatives to corporate consolidation.

COMBATING VERTICAL CONSOLIDATION

The first set of policies is aimed at combating emerging forms of vertical consolidation. Most pressingly, policymakers should address the vertical consolidation that is being fueled by the MA program. These policies range from near-term and most feasible, to more structural.

Require Transparency in Ownership: Nontraditional corporate entities, such as insurance companies and private equity, increasingly use complicated and obscure corporate structures that are difficult for patients, the public, and researchers to track. To address this, the Biden administration recently finalized rulemaking that requires nursing homes to disclose information related to ownership, management, and financial control.¹⁵² This sort of transparency should be applied sector-wide. In Congress, the Lower Costs, More Transparency Act, which was recently released but not passed by Republican

151 Nicholas Bagley, “[Medicine as a Public Calling](#),” *Michigan Law Review*, 2015.

152 Tonya Williams Scharf and Abbey Mansfield Ruby, “[CMS Issues Final Rule on Ownership Transparency](#),” Holland & Knight, November 20, 2023.

House leaders, only requires ownership transparency for providers owned by MA plans.¹⁵³ However, it excludes similar requirements for all providers, including disclosure of the sophisticated contracting arrangements often used by private equity owners that enable them to exert functional control over medical practices without direct ownership (more on this below).¹⁵⁴ States could also take up these transparency efforts.

Reduce MA Overpayments: Scholars have mapped out at least a dozen ways to address these overpayments through regulatory and legislative action, the savings of which could be used to reinvest in Medicare.

To rein in risk adjustment, CMS could, for the first time, increase the “coding intensity adjuster” beyond the statutorily required 5.9% adjustment to correct for risk-score inflation. This would be the most straightforward solution for CMS and reduce payments by roughly \$600 billion in the next eight years.¹⁵⁵ But it would be a blunt instrument that retains the incentive for individual plans to risk code as much as possible and seek overpayments. A more targeted approach would be to alter the risk adjustment model to rely less on traditional Medicare as the risk comparator, or by specifically removing certain abusive risk scoring tactics from measurement, such as chart reviews and home-based risk assessments.

CMS could also build on its 2023 rulemaking to address wholly fictitious risk documentation. Unlike the solution above, which addresses (generally) valid diagnoses from physicians, risk adjustment data validation audits (“RADV audits”) are meant to capture diagnoses submitted by plans that are entirely erroneous and unsupported by the clinical record. The current rule was a modest step in the right direction, and CMS could significantly bolster the impact of these audits by extending the retrospective lookback period, devoting more resources to allow for more audits, and imposing penalties for erroneous submissions (rather than merely requiring repayment).¹⁵⁶

With respect to quality bonuses, CMS could make it more difficult for the plans to achieve the 4-star level, at which they receive their 5% bonus. To address overpayments that result from favorable selection, CMS could vary risk adjustment by geography, or alter the geographic region that is used to calculate MA benchmarks on the basis of traditional Medicare spending in that “local area.”¹⁵⁷

153 Yashaswini Singh and Erin C. Fuse Brown, “The Missing Piece In Health Care Transparency: Ownership Transparency,” *Health Affairs*, September 22, 2023.

154 Id.; Jane Lucas, Scott Kummer, and Rob Stone, “How Is Congress Trying to Regulate Private Equity in Health Care?” Alston & Bird, August 21, 2023.

155 Erin C. Fuse Brown et al., “Legislative and Regulatory Options for Improving Medicare Advantage,” *Journal of Health Politics, Policy and Law*, December 1, 2023.

156 Id.

157 Id.

However, legislative action would be the superior intervention for cost savings because Congress could directly capture savings generated from MA. In addition, Congress could make fundamental changes to the way that CMS calculates benchmarks, or the way that plans bid for them. Congress could also make the quality payment program budget neutral, or do away with it.

Update Medical Loss Ratio (MLR) Requirements: In addition to reducing MA over-subsidization, policymakers should more tightly regulate MA plans to protect against gaming and vertical consolidation. To limit the MLR gaming described above, Congress can require disclosure of transfer prices and establish benchmarks to ensure that conglomerates are paying market rates to sister companies.¹⁵⁸ In addition, Congress should consider raising the MLR, now set at 85%, to require that public money is spent on care, not profits and consolidation. While raising the MLR in the commercial market could have unintended consequences (e.g., insurers raising prices), the same concern ought not to apply in MA. Under MA's bid structure, benchmarks are established based on fee-for-service spending, and if bids increase above the benchmark, then plans are required to pay the government. Therefore, there is a built-in price constraint that does not exist in the employer or individual market.

Invest in Traditional Medicare: Policymakers should use savings from MA reform to directly invest in Medicare. Such savings, which could be upwards of \$100 billion annually, would be significant “pay-fors” to, for example, lower premiums and other cost sharing for beneficiaries, implement an out-of-pocket cap, cover hearing and dental, and invest in primary care. In addition, providers are increasingly denying traditional Medicare patients and are instead only contracting with MA plans. This directly undermines the guarantee of traditional Medicare—that patients have an open network to see any provider. This pattern is especially concerning as primary care practices are increasingly sister companies of MA insurance plans. Congress can ban the practice of denying traditional Medicare.

Enforce Antitrust Laws: In December of 2023, the FTC and DOJ updated their merger guidelines, signaling greater agency emphasis on vertical consolidation and more rigorous standards for merger review.¹⁵⁹ Beyond stronger guidelines, the antitrust agencies need more enforcement power. Compared to 1979, the Department of Justice antitrust division has over 200 fewer staff, which Congress could rectify with greater funding for the DOJ and the FTC; this could be general funding or directed to health care specifically, as proposed in the Hospital Competition Act.¹⁶⁰ Congress could also strengthen the antitrust

158 Richard G. Frank and Conrad Milhaupt, “Related businesses and preservation of Medicare’s Medical Loss Ratio rules,” Brookings, June 29, 2023.

159 “FTC and DOJ Release Finalized Merger Guidelines,” Hall Render Blog, December 27, 2023.

160 Andy Forman, “Deputy Assistant Attorney General Andrew J. Forman Delivers Remarks to Capitol Forum: Health Care Competition Conference,” United States Department of Justice, October 26, 2023; “Senator Klobuchar Introduces Sweeping Bill to Promote Competition and Improve Antitrust Enforcement,” US Senator Amy Klobuchar, February 4, 2021.

statutes to make large mergers and vertical mergers more presumptively unlawful, as well as overturning bad case law on the Sherman Act.¹⁶¹

State AGs and other enforcement bodies can also scrutinize transactions. In the past decade, seven states have established enforcement agencies specifically dedicated to scrutinizing health care transactions beyond the traditional domain of nonprofit hospitals.¹⁶² Requirements range from simple notice to approval from the state.¹⁶³ Notably, these bodies need not be solely focused on antitrust. In Oregon, which is thought to have the most expensive regulatory authority, the Health Care Market Oversight (HCMO) board can block transactions if they pose risks to controlling costs or improving access, equity, and quality.¹⁶⁴ However, across the states, it remains too early to tell whether enforcement will be sufficient to slow corporate consolidation. Notably, Oregon undertook an extensive review of Amazon's One-Medical purchase but ultimately approved it.¹⁶⁵

A Glass-Steagall for Health Care: Under current statute, to address the harms of vertical consolidation, the antitrust agencies must work within the statutory confines of the Clayton Act, which primarily prohibits mergers where the effect “may be substantially to lessen competition, or to tend to create a monopoly.”¹⁶⁶ Enforcing limits on vertical consolidation this way requires repeatedly proving its negative effects on competition through litigation. But Congress itself faces no such constraints when addressing vertical mergers. One idea would be to simply outlaw payer-provider integration—a sort of Glass-Steagall for health care. The Glass-Steagall Act, passed in 1933 in response to the Great Depression but repealed in the late 1990s, prohibited banks from being both commercial and investment banks because it was thought to pose a systemic risk. A Glass-Steagall for health care would take a structural position against the vertical consolidation of insurers and providers, recognizing the inherent conflict and risk associated with being on both sides of this relationship. This proposal would ban insurers and PBMs from owning pharmacies, including mail-order and specialty pharmacies, and it would ban insurers from owning medical providers.

Update and Repurpose Prohibitions on the Corporate Practice of Medicine: States, with the assistance of the federal government, can update bans on the corporate practice of medicine (CPOM) to prohibit or limit insurance, private equity, and other forms of corporate ownership of physicians. Historically, CPOM bans have barred lay corporations

161 For example, *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2 (1984), permitted exclusive contracting between different medical providers (a hospital and its anesthesiologists), assuming that such contracting is efficient and benefits patients. Such precedent, however, may give greater authority to exclusive contracting of insurance conglomerates.

162 Brett R. Friedman, Benjamin Wilson, and Natalie LaRue, “[Value-based Care Collides with Competition: Recent Developments on the East Coast](#),” Ropes & Gray, May 31, 2023.

163 *Id.*

164 Robin Davison, “[A Step Forward for Health Care Market Oversight: Oregon Health Authority’s Health Care Market Oversight Program](#),” Milbank Memorial Fund, March 13, 2023.

165 “[Transaction 005 Amazon & One Medical 30-Day Review Summary Report](#)” Oregon Health Authority, December 28, 2022.

166 “[15 U.S. Code § 18 - Acquisition by one corporation of stock of another](#),” Cornell Law School Legal Information Institute.

from owning, employing, or controlling medical practices. In the 1970s and 1980s, however, with the rise of the managed care movement and mistrust of the AMA's monopoly power, regulators at the state and federal level began to erode CPOM bans. Most importantly, lawyers crafted a workaround, known as the “friendly” or “captive” professional corporation (PC) model, to allow lay management corporations to exert de facto control over medical practices.¹⁶⁷ States could close these loopholes and workarounds with properly drafted legislation—and some are beginning to try. Legislators in Oregon have recently introduced a first-in-the-nation bill to specifically regulate the friendly PC model as used by private equity, insurance conglomerates, and national retailers.¹⁶⁸

At the federal level, congressional leaders could pressure their states to enforce these laws, and the agencies could update guidance that has, for the past number of decades, been suspicious of CPOM.¹⁶⁹ Further, Congress could repeal the HMO Act, which pressured states to create managed care exceptions to their CPOM laws. Though not historically the purview of the federal government, Congress could establish a federal CPOM ban, as was recently debated by the AMA House of Delegates.¹⁷⁰

Regulate Facility Ownership: While CPOM bans can combat the encroachment of management companies and require physician ownership of medical practices, they do not address ownership of facilities and non-physician providers. For example, CPOM bans—as historically understood—do not regulate ownership of hospitals, nursing homes, dialysis clinics, or home health agencies. However, states and the federal government can, and historically have, directly regulated the ownership and governance of these providers. Specific to emerging forms of vertical consolidation, Medicare used to ban for-profit entities from existing as home health or hospice providers.¹⁷¹ Similarly, Medicare did not initially allow for-profit entities into the Program of All-Inclusive Care for the Elderly (PACE).¹⁷² Renewed scrutiny of ownership also would also apply to hospitals and nursing homes. For example, regulators could ban PE ownership of nursing homes, or revoke the nonprofit distinction for nonprofit hospitals that employ predatory financial tactics while stinting on charity work.¹⁷³

Support Countervailing Power: Federal and state officials can also take steps to empower physicians and other clinicians. Corporate owners routinely use noncompete agreements, gag clauses, and other restrictive covenants to control physicians and bind

167 Jane M. Zhu, Hayden Rooke-Ley, and Erin Fuse Brown, “A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine,” *The New England Journal of Medicine*, September 14, 2023.

168 Jake Thomas, “Bill seeks to curb corporate control of health care in Oregon,” *The Lund Report*, October 31, 2023.

169 Carl F. Ameringer, “Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association,” *Journal of Policy History*, 2000.

170 Maureen Tkacik, “The AMA Debates a Federal Ban on Corporate Medicine,” *The American Prospect*, November 13, 2023.

171 Eileen Appelbaum, Rosemary Batt, and Emma Curchin, “Profiting at the Expense of Seniors: The Financialization of Home Health Care,” Center for Economic and Policy Research, September 26, 2023.

172 David Dayen, “Patient Zero,” *The American Prospect*, August 1, 2023.

173 “US: Nonprofit Hospitals Chase Low-Income Patients on Debts,” Human Rights Watch, June 15, 2023.

them in place. The FTC proposed a ban on noncompete agreements in January 2023, which would apply across industries, but final rulemaking was delayed until 2024. States could do this, as well, and some already do. The federal government and the states can also provide due process protections for physicians who are fired by lay corporations that do not formally employ them but that exert de facto control over them through contracting. This issue has direct application to the hospital setting, as well. For example, an emergency room physician working for a PE-owned staffing company may be removed, without due process, via coordination between the PE firm and the hospital.¹⁷⁴ Finally, there is a growing desire for physicians and health professionals to unionize, as seen with nurses, pharmacists, and physicians working for UnitedHealth, private equity companies, and large hospital systems.¹⁷⁵ Physician unionization offers a vehicle for collective power, providing an institution for physicians to reclaim control of medical practice and to engage in policy transformation. Federal and state legislators can support the growing unionization efforts of physicians and other medical professionals by enacting legislation that makes it easier to unionize.

BUILDING RESILIENT HEALTH CARE INFRASTRUCTURE

Ultimately, combating corporate consolidation requires more than just “defense.” Practicing medicine independently today is an immense challenge. Our fragmented, multi-insurance system, with its labyrinth of payment and compliance policies, has made every physician-run clinic vulnerable to acquisition. Today, these physician practices generally have one option: sell to the corporate giant, whether a hospital, insurance conglomerate, or PE investor. An adequate policy response therefore requires alternatives. Though far from comprehensive, the following recommendations offer first steps, with an emphasis on primary care, the backbone of any strong health care system.

Produce and Allocate Physicians: Because the government directly funds medical residency slots, it is well positioned to dictate the scale and specialty distribution of the physician supply. The current primary care physician shortage is worsening by the day. By 2034, it is estimated that there will be a shortage of up to 48,000 primary care physicians.¹⁷⁶ This can be rectified with a significant increase and reallocation of primary care residency slots. Medicare should also use its bargaining power to ensure that there is an adequate pipeline of medical students to place into primary care and other underserved specialties. This would require coordination with medical schools, prior to residency, to ensure that

174 Greg Jasani and James Maloy, “Emergency department physicians should have the right to due process protection. Many don’t,” *Stat News*, December 16, 2020.

175 Arielle Dreher, “More physicians unionize in the face of burnout, consolidation,” *Axios*, November 7, 2022.

176 Andis Robeznieks, “Doctor shortages are here—and they’ll get worse if we don’t act fast,” American Medical Association, April 13, 2022.

their admissions practices align with societal needs. These questions of access will also implicate debates around telemedicine and scope of practice, which deserve serious policy attention and evidence-based solutions made in the interest of patients and the public.

Invest in Primary Care and Fix the RUC: Attracting physicians into under-supplied specialties like primary care calls for increased investment and for compressing the range of physician reimbursement. Indeed, evidence indicates that a significant driver of specialty choice is the pay disparity between possible specialties.¹⁷⁷ Here, again, Medicare plays a central role in organizing the physician supply through its control over reimbursement rates for services, known as the Medicare Physician Fee Schedule (MPFS). Not only does the MPFS set rates for Medicare, three-quarters of the services physicians billed to commercial insurers are pegged to Medicare’s relative prices, and numerous Medicaid programs use the Medicare rates as a benchmark.¹⁷⁸ Medicare policy is moving in the right direction with recent MPFS increases to primary care, but the magnitude is wholly insufficient. As recently recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), pay rates for primary care should increase by 50%.¹⁷⁹

One perennial barrier to compressing pay disparities between primary care and specialists is that the American Medical Association (AMA) all but sets the MPFS through its control of the RVS Update Committee, or RUC. Shortly after Medicare implemented the MPFS, the AMA created the RUC to provide recommendations to CMS in setting reimbursement rates for physicians. Between 1994 and 2010, CMS accepted 87.4% of the RUC’s recommendations, unaltered. The RUC has minimal primary care representation, and research shows that the RUC inflates the relative value, and hence the reimbursement, of specialty services.¹⁸⁰ While it is useful to have physician input from their institutional representations, it should be just that—input. Medicare ought to have its own version of the RUC within CMS, which would independently determine the relative value of physician services as the basis for reimbursement. One modest proposal put forth by a group of Medicare experts is to establish an expert advisory panel (EAP) within CMS to provide advice for adopting more accurate relative values.¹⁸¹

Simplify Financing: Training more physicians and properly allocating and paying them will begin to address shortages, but reforms must address the “push” factors that cause many physicians to opt for corporatized medicine. Radical simplification is needed. In primary care, payers should pay providers per-patient, lump-sum payments, with minimal,

177 Michelle Andrews, “Report suggests compensation is key to fixing primary care shortage,” *Kaiser Family Foundation Health News*, November 24, 2023.

178 “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care,” National Academies of Sciences, Engineering, and Medicine, 2021.

179 *Id.* at p. 373.

180 “Composition of the RVS Update Committee (RUC),” American Medical Association, June 29, 2023.

181 Robert A. Berenson, “Comment on NPRM Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements,” September 2, 2022.

easily measured quality metrics.¹⁸² While providers would receive lump-sum payments, they would not assume the total-cost-of-care “risk-bearing” function that characterizes capitation-based models. That is, primary care providers would not assume the insurance function of managing total costs; they would be paid the 5-10% of an individual’s total health spending that goes toward primary care. Further, risk adjustment would be based on demographic and other factors, not diagnostic coding. Omitting these two elements would protect against the corporatization of primary care seen today. While this sort of financing could be integrated into insurance, a more ambitious alternative is to remove primary care from private insurance and provide it directly for all. Irrespective of the direct payer, this primary care reimbursement model would go to practices of diverse organizational types, including small private practices, group practices, community health centers, county clinics, and other types of primary care practices.¹⁸³

Promote Physician and Public Ownership: States and the federal government can promote physician-led ownership through direct investment and through the tax code. For example, Indiana recently enacted a tax credit for independent physician-led practices.¹⁸⁴ States also have numerous tools to publicly acquire struggling practices (and hospitals). For example, health and hospital districts exist in localities across the country as a means of locally financing and owning health care infrastructure. These districts are locally governed, often directly elected or appointed by the county, and they have the authority to issue bonds and raise revenue for the purpose of financing or providing health care. For struggling practices or hospitals, this could be an alternative to selling to private equity or a national conglomerate. Further, states and the federal government should increase funding for local public health departments, which would support efforts to directly provide medical care.

Health Care as a Public Utility: As noted above, health care industrial policy means moving away from private utilization rationing as the primary means of cost containment—that is, placing less reliance on private insurance (e.g., MA) and risk-bearing primary care providers (e.g., ACOs) to be managers of total costs. Instead, cost-containment should emphasize the main drivers of excessive spending: high (and disparate) prices, as well as administrative bloat and profits. This necessarily implicates the regulation of hospitals, which are the largest source of health care spending and which have also become corporatized and profit-driven. By incorporating tenets of public utility law, policymakers can effectively contain cost and, similar to primary care, correct the maldistribution of capacity. While a full account of hospital policy is beyond the scope of this paper, the following proposals outline a path forward.

182 Kevin Grumbach, *Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good*, *Annals of Family Medicine*, March 2023.

183 Eyal Press, “The Moral Crisis of America’s Doctors,” *New York Times*, June 15, 2023.

184 “House Bill 1004,” *Indiana General Assembly*, 2023.

Medicare can strengthen nondiscrimination laws and the conditions of participation to ensure that hospitals serve all patients and do not desert less profitable geographies. The more systemic fix to disparate access is to standardize payment rates. States can begin to do this by pegging commercial prices to Medicare rates, as some recently have.¹⁸⁵ Even better, states and the federal government should move toward all-payer rate-setting, which would eliminate the differences in reimbursement between providers. Ultimately, payment should move toward “operational” global budgets. Unlike Maryland’s financing programming, which is often referred to as global budgeting, true operational global budgets would capture significant savings by moving away from per-service billing and coding.¹⁸⁶ In addition, operational budgets would strictly fund operations, capping profits and administrative waste. It would also remove the expansionist impulses of current hospital systems by untethering capital financing from operations.

185 Michael E. Chernew, David M. Cutler, and Shivani A. Shah, “Reducing Health Care Spending: What Tools Can States Leverage?,” The Commonwealth Fund, August 18, 2021.

186 Adam Gaffney et al., “Hospital Expenditures Under Global Budgeting and Single-Payer Financing: An Economic Analysis, 2021–2030,” *International Journal of Social Determinants of Health and Health Services*, January 30, 2023.

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